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# Planning Ahead

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HOLIDAYS ARE OVER for most of us this month. Settling down to work again has many opportunities for pleasant interludes when we can compare notes on where we have been, what we have seen and done. There will be hundreds of snapshots exhibited, happy moments recaptured in the telling, new plans for future vacations.

It is in connection with possible plans for 1952 that attention is drawn to a special summer school to be held under the auspices of the "Old Internationals' Association," Florence Nightgale International Foundation. It is scheduled for the period July 10-19, 1952, at Bedford College for Women, University of London, England. Tentatively, the title of the course has been slated as "Human Relationships," a truly engrossing topic to consider. There will be accommodation for 70-80 residents. Applications from "Old Internationals" will be given priority. Any remaining accommodation will be allocated to other nurses in order of application. If, therefore, any plans are afoot for a European trip next summer, nurses would be well advised to apply early to avoid disappointment.

District, chapter, and alumnae associations will be drawing up plans for their fall and winter meetings this month. Many of these groups had the privilege of hearing our general secretary speak during her tour last spring. Such contacts pay rich dividends. They bring a broad concept of the whole picture of nursing in Canada to the local group. They revitalize the individual nurses, giving them a keener awareness of their personal importance and responsibility in the professional nursing picture. They provide the visiting speaker with a needed glimpse at local situations so that a broader, more explicit interpretation can be given of the whole field of nursing in our country. Every opportunity for this exchange of ideas should be seized by our active local groups in planning their winter programs.

It is not too soon to begin making plans to attend the next convention of the Canadian Nurses' Association. The place is well known to most nurses—beautiful Chateau Frontenac, Quebec City. The entire hotel has been reserved for our use during the

first week of June next year. Because it is anticipated the attendance will far outstrip the space accommodation at that famous hotel, additional lodgings are being secured in smaller inns. Beginning early next year the details regarding the program will be published. Whatever it is, it will be good ! For the benefit of the pocketbook begin your planning now so that an already strained budget (more evidence of planning!) can be stretched to include transportation to and living costs in Quebec City.

# The Effects of Atomic Radiation

Z. S. HANTCHEF, M.D., D.P.H.

*Average reading time — 15 min. 48 sec.*

(*Concluded from August issue*)

TREATMENT OF RADIATION SICKNESS

Before examining what can be done to save as many people as possible in the event of an atomic raid, we shall consider how radiation sickness can be treated. Since 1945 there have been ceaseless experiments on the Japanese victims and on animals in the laboratory.

Little can be done in the way of treating radiation sickness when the acute dose is 600 roentgens or more but if the dose is smaller—e.g., 400 roentgens—many lives can be saved with proper treatment. Immediate hospitalization, so as to ensure complete rest and avoidance of chills and fatigue, is the essential first step.

Whole blood transfusions should be given until the bone marrow has had time to regenerate and produce blood cells.

Adequate nourishment should be applied through intravenous feeding to supply the necessary sugars, proteins, vitamins, etc.

To help the system deprived of white blood cells to fight infection, antibiotics should be used: penicillin, streptomycin, and aureomycin. The latter would also have a certain effect against hemorrhages. The whole subject of radiation sickness is being given extensive study and important advances in its treatment may be expected.

Among suggestions already made or tried may be mentioned the use of vitamin P, or rutin, against the hemorrhagic syndrome. This substance counteracts the fragility of the small vessels and regularizes their functioning. Radiation doses, which are always lethal among non-treated animals, cause only 10 per cent of deaths among animals treated with rutin (or lemon peel which contains it). Rutin should be given at the rate of 10, 15 or 20 tablets per day. If an excess of heparin is observed in the blood, toluidine blue can also be given intravenously, and protamine sulphate.

Anemia can be fought by means of whole blood transfusions. As the transfusions would have to be constantly renewed, a great deal of blood would be required—i.e., 15 pints (or 7-8 litres) per person.

Other useful medicaments are vitamins $B_1$, $B_6$, C and PP. The destruction of vitamins is a well known effect of radiations. Folic acid and pyridoxine can also be given. Montag proposes the following initial treatment:

| | |
|---|---|
| Ascorbic acid (vit. C.) | 0.50 |
| Neurin (vit. B) | 0.01 |
| Nicotilamide (vit. PP) | 0.10 |

All this would be given in a single intravenous injection which would be repeated if necessary.

The usual treatment would be used against dehydration caused by diarrhea and vomiting.

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Reprinted from the *International Health Bulletin* (Oct.-Dec. 1950) of the League of Red Cross Societies, Geneva, Switzerland.

The Atomic Energy Commission is also studying the possibility of encouraging resistance to radiation by female sex hormones, cystine in injection, methionine, glutatium, and tryptophane.

In cases of ground or water bursts, when radioactive particles may have been absorbed, zirconium may be employed in small quantities, as it provokes a rapid elimination of the plutonium remaining in the system.

American specialists are unanimous in recognizing that there are no specific medicines for radiation sickness. All that can be done is to help the resistance of the system until the bone marrow and the blood are regenerated. In August, 1950, one of the members of the Atomic Energy Commission stated: "We are still at the stage of counting on the human system to cure itself."

Moreover, it must not be forgotten that victims of radiation sickness may also suffer from burns and injuries. This will complicate the task of the doctors. The first injuries to be treated are burns, shock, and lacerations. Radiation sickness is less urgent.

### Residual Radiation and Its Dangers

In the book we have mentioned, *Effects of Atomic Weapons*, which is the best authority on the subject, the dangers of residual radiation are only studied "for the sake of completeness." These dangers are, however, not very likely to arise.

It is known that residual radiation is due: (1) to fission products, particles of plutonium, and other radioactive metals which have escaped disintegration and continue to release radiations. They are like minute bomb splinters, reduced to dust, but a dust that can be very dangerous; and (2) to the effect of neutrons on the atoms of the soil and other structures.

If the bomb explodes in the air as in Japan, and as would be the most frequent case, the danger is almost non-existent. The dust is too widely dispersed.

If there is a risk, it is perhaps from the wind in the area where the dust has fallen back to earth (the fall-out area). The risk is still greater in the case of rain, which would bring the dust to earth again and, in this case, clothing and body-surfaces would be contaminated by radioactive dust. The cases where this would present a real danger would be:

(a) The explosion of the atomic bomb on or below the surface of the ground, as in the experiment in the desert in New Mexico.

(b) An underwater explosion (Baker test at Bikini).

When the bomb explodes under water—i.e., in deep water—it forms a column of water which spreads out in the form of a mushroom or cauliflower. The photographs are well known. At the base of the column there develops a gigantic circular wave of mist (base-surge) which travels outwards. This thick cloud of droplets moves from the centre of the explosion and is gradually lifted until it assumes the appearance of a mass of strato-cumulus, from which rainfall rapidly develops. At Bikini the rain lasted for more than an hour. This wave of mist and the rain it produces are radioactive and can be dangerous over a distance of several miles.

It is, however, much more likely that the bombs would be exploded in the air above their objectives but for the sake of completeness we shall also examine the dangers of residual activity. A distinction should be made between external radiation (where the source of radiation lies outside the body) and internal radiation where the source is taken into the body by ingestion, inhalation, or through breaks in the skin.

*External radiation:* Alpha particles are unable to penetrate the outer layers of the skin and are consequently of no importance as an external radiation danger. Beta particles can penetrate a few millimeters of tissue. They do not penetrate to vital parts of the body but can cause superficial swelling, hematomae, blisters and ulcers which take some time to heal. So

far, these effects have only been observed in scientists working with radioisotopes. The gamma rays which might be emitted are at least four times less penetrating than the gamma rays emitted instantaneously by the explosion of the bomb. Moreover, it is not likely that many persons would remain in the contaminated areas long enough to accumulate dangerous doses.

*Internal radiation:* Even in the case of a contaminating explosion, the chances of a dangerous amount of radioactive material entering the system are very small. No form of internal radiation was observed in Japan. To constitute an internal radiation danger the active materials must gain access to the blood stream; they must be digestible. If not, they will only pass through the digestive tract and will not remain there long enough to cause any damage. Most of the fission products present after an atomic explosion are almost insoluble in the body fluids. The greater danger would be the entry of radioactive material into the system through open wounds, as they would enter the blood stream directly and be deposited in the body. The inhalation of radioactive dusts is also scarcely likely to be a danger, as the hairs in the nostrils will filter out particles exceeding 5 microns. Particles from 1 to 5 microns can pass from the alveolar space of the lungs to the blood stream or reach the lymphatic system. These facts are important in connection with the design of air filters and respirators for reducing the extent of inhalation of radioactive dusts.

## Decontamination

There are three means of minimizing the dangers associated with radioactive contamination:

1. To dispose completely of the material by deep burial in the ground or in the sea.
2. To keep it at a distance for a sufficient time to permit the radioactivity to decay to a reasonably safe level (in sea water, the sodium salt will be the chief radioactive substance and will remain radioactive for about three days).
3. To attempt to remove the contaminant — that is, to decontaminate the material.

These three methods were used in connection with the ships in the Bikini test. With large structures, which it is impossible or undesirable to dispose of, there can be no questions of burial and it is best to leave them until the activity has decayed to some extent. An aircraft carrier at Bikini received such a large radiation dosage that if there had been any personnel they would have succumbed to radiation sickness. Yet two weeks after the explosion, the radioactivity had already diminished sufficiently to permit short time access. A year later, the average dosage rate was no more than 0.4 r. per day and three years later the ship was once more in use, without danger to anyone. Other vessels were decontaminated.

Decontamination of surfaces can be carried out by chemical or physical means. No chemical product can suppress radioactivity but an active isotope can be converted by chemical reaction into a soluble radioactive compound which can then be washed off. When radioactive products manage to soak into porous materials such as rope, textiles, unpainted or unvarnished wood, etc., the problem is more difficult. The decontamination of water is yet another matter.

The problem of decontamination is far from being solved. At present, the best procedure is to try various methods successively until the desired result is obtained.

One of the most effective *physical methods* for the decontamination of large surfaces, such as those of a battleship or a building, is wet sand-blasting, which was used for the target vessels at Bikini. Sawdust and steel wool have also been suggested. Wet sand-blasting has the advantage of being a part of normal ship maintenance and the equipment and trained personnel are generally available. If *chemical means* are used, they must be capable of being easily stored and must be carefully selected. Products soluble in water are always

preferable and can be used with standard fire-fighting equipment.

A problem which should not be forgotten is that of the disposal of the liquid used for decontamination. Sand and water will contain the radioactive material they have removed and care must be taken to avoid their contaminating other objects or places but in all procedures using water the radioactive products are generally too diluted to be dangerous. For painted surfaces the most effective method is the use of alkalis. In general, physical and chemical procedures should be combined: the combination of live steam and a detergent may be applied to a large number of surfaces and objects.

Rough surfaces retain radioactive products more easily than smooth surfaces and it can happen that radioactive dusts tend to become attached to such surfaces as a result of treatment with water. It was possible to suppress the radioactivity remaining on the ships at Bikini simply by using brushes and vacuum-cleaners.

On smooth surfaces which have been contaminated, it is possible to use adhesive materials such as sprayed coatings (which form a thin film when dry), adhesive tape, and all substances which, when removed, retain the radioactive material.

The walls of certain laboratories are now being covered with three coats of "prufcoat," a thick paint, which is sprayed with a fine film of rubber called the "cocoon." This enables the contaminated part of the wall to be removed and replaced by new coats of paint. The method takes 48 hours' work, five days to dry, and costs about $155 for a small laboratory. Considering the work required to treat porous wall and eliminate the radioactive material absorbed and also the cost of this operation, the expenditure of time, money, and work required by the new method appears negligible.

When surfaces are rough and strongly contaminated, chemical methods should be applied which would transfer the radioactivity to a liquid phase which can then be washed off. In this connection three general principles have been employed:

1. Formation of soluble complexes.
2. Ion exchange.
3. Solubilization.

Much research has been conducted with the object of finding products which form complexes with the fission products. So far, sodium citrate solutions, sodium salts of ethylenediaminetetracetic acid, aminotriacetic acid, and pyrophosphoric acid have been employed. Strongly acidified citric acid solutions are the most effective. Hydrochloric acid also dissolved rust and scale where the contaminants tended to concentrate. Some contaminants respond to the action of wetting agents and detergents. The peptizing properties of these substances allow the particles of insoluble material to be washed away. The use of a detergent in any decontamination procedure is beneficial because, in addition to the solubilizing effect, it facilitates the wetting of the surface and, as noted earlier, the removal of dust, dirt, etc., carrying radioactive material. It should not be forgotten that these decontamination processes do not neutralize the radioactivity; they merely transfer it from one place to another. Before undertaking decontamination, arrangements should be made so that the water and substances used do not represent a danger to other objects.

*City and domestic decontamination:* In the event of serious radioactive contamination, the most important steps would appear to be the removal or coverage of loose material which might form dust that would be inhaled or ingested with food. For paved streets, the best procedure would be flushing with the aid of detergents (soap, alkali, or soda) or vacuum sweeping. Concrete, stone, and brick buildings would perhaps have to be sand-blasted with a fire hose and reroofed, as the roofs would have received the greatest amount of radioactive material. Soil tends to concentrate radioactive material. The only solution would be to cover it with fresh soil or simply to turn it over. It is always wise to water it first

to minimize the dust danger. Cloth, clothing, blankets, and upholstered furniture should be burnt but care should be taken in doing this as the smoke would be radioactive. If the contamination is not too serious, laundering may be effective in removing and diluting radioactive dust.

*Decontamination of food and water:* Properly covered foods, such as preserves, would not be contaminated and there is no means of decontaminating unprotected food.

In general, there should be little danger from contaminated water, except for a short period immediately following the explosion. If reservoirs or dams were contaminated, the radioactive material would be considerably diluted; moreover, it would tend to settle on the bottom and as the normal water-purifying systems in use include sedimentation and filtration, almost no radioactive material would reach the consumer. If there is no purification system, the water can be dangerous for several days. If chlorine is the only means of purification in a town, domestic water softeners should be used. Distillation is effective but the public should be warned that the mere boiling of water is of no value in this case. Finally, the radioactivity of the water diminishes very quickly.

The foregoing remarks concern only a contaminating explosion. It can be seen that, even in this case, which would be rare, the danger is, on the whole, not very great.

### Radioactive Substances as Weapons of War

Another use of radioactivity with a destructive aim is the simple use of radioactive substances and a fifth column could be instructed to place these at strategical points (radiological warfare). In fact, the atomic bomb can be considered as an indirect radiological weapon as its principle object is to cause material damage and radiation sickness is only of secondary consequence. Radioactivity can, however, be used as a weapon, independently of the atomic bomb, through the mass employment of radioactive substances, such as those which are known to cause injuries to scientists in their laboratories.

For this purpose by-products from the manufacture of atomic bombs could be used. These substances can also be manufactured separately. The enemy would no doubt choose substances emitting very penetrating gamma rays against which protective clothing and gas masks are ineffective and would deposit these substances in particularly important towns and centres. The interesting feature of this weapon is its secrecy. Theoretically, it could affect and kill the inhabitants without causing destruction or panic. It takes up little space and a few pounds of these substances would be enough to release vast quantities of radiation. Finally its mysterious nature adds to the psychological effect.

However, it does not seem that this is a very serious danger. First of all, the radioactivity of a substance diminishes in the course of time. It might be said that the more powerful it is, the faster it diminishes and extremely radioactive substances can become 10,000 times less powerful within 24 hours. It cannot, therefore, be stored, and must be manufactured continually. The persons entrusted with the task of placing it must also be protected and the substances which act as protection against gamma rays are heavy (concrete, iron, lead). Finally, the radioactivity thus employed only acts over a period, which prevents it from being a tactical weapon in the military sense. In a fast-moving war it could become a two-edged weapon.

The best method of fighting the radiological weapon is to understand it and prepare for it. It can easily be detected by certain devices which are very sensitive to radiations. It would, therefore, suffice to evacuate the contaminated area for a time.

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According to statisticians, 7 out of 10 boys in the 18 to 20-year age bracket have taken jobs and somewhat less than 10 per cent of them are married. Among the girls in this age group, about 45 per cent are employed, about 35 per cent are already married.

# The Enema — A Neglected Art

H. W. Schwartz, M.D.

*Average reading time — 9 min. 36 sec.*

I own that I fear my narrative will appear to you as the production of a disordered mind, the effusion of low spirits and an irritable disposition, and that you will regard me as the voluntary victim of a morbid sensibility. I wish for my own sake that this were the case, and that the day might arrive, when I could look back upon the degradation and misery I have recently suffered as only imaginary. But, alas! my dear fellow, it is no phantom of the brain, but sad reality — reality, do I say? — it falls far, very far short of the reality, which no words can paint, no pen describe.— *From the Letter-bag of the Great Western*—Thomas Chandler Haliburton, 1796-1865.

Anyone who has ever been reduced to the necessity of using a bed-pan has complained but few have tried to do anything about it. Recently the writer was compelled to spend six weeks in the horizontal position and can only make suggestions from the experience thus gained. To lie flat on the back on a bed-pan was a back-breaking position and great relief was secured by placing support beneath the lumbar region. When I was taken to hospital I took with me the "Dunlopillo" cushion off my office chair and used it for this purpose with a fair degree of satisfaction. A wedge-shaped support made of this or similar elastic, compressible, cushion-like material — probably an inch thicker than the depth of the pan at its lower end and tapering off to an inch or less in thickness at its upper end — that would reach to a little below the shoulders of the average individual, should be provided. I am confident that such a simple and inexpensive auxiliary would give great comfort to the bed-ridden.

Regarding the pan itself — there is a decided tendency for the weight of the body, which rests near its posterior edge, to tilt the anterior end up. It requires comparatively little pressure applied anteriorly, due to its leverage, to correct this tendency. I would suggest that more weight be incorporated in the anterior one-sixth by making this part of the vessel heavier.

My impression is that the giving of an enema is looked upon as a dirty, disagreeable chore rather than a therapeutic measure that not only gives immediate comfort but plays an important part — both physically and psychologically — in hastening recovery. On the whole, my observations would lead me to believe that those assigned to render this service have received little if any supervised training. Their instructions were no more detailed than to introduce a tube into the bowel, to run in a quantity of some fluid and to catch it when expelled, if at all convenient. The average pick and shovel laborer — selected at random — would not measure up unfavorably as the attendant!

Once I made so bold as to suggest that perhaps it might be better if some protective covering be placed beneath me "just in case." I was assured by the attendant that he seldom, if ever, had an accident. Unfortunately, I was the exception. Both the sheets were soiled and I was compelled to remain on my side, which for me was a painful position, until the female nurse arrived to change the bedding. The more personal attention consisted of a few half-hearted wipes with some glazed toilet paper. I was left uncomfortable, feeling and knowing I was not clean—but the attendant was quite satisfied, and why not? He had undertaken to empty the bowel and had succeeded beyond his expectations! It never entered his good-natured head that lifting and turning the ill or injured might provoke a great deal of pain and that there might be some relationship between

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the way he did his work and the comfort of the patient.

To have an ice-cold bed-pan placed beneath you and be assured that if you stay on it long enough it will warm up may sound like a very amusing practical joke. When a person is quite ill his outlook is not normal, his sense of humor is apt to be distorted, and such carelessness fails to amuse.

My next enema was given at a world-renowned hospital by a gentle elderly soul who appeared with an unusually large can and yards of tubing. I must acknowledge to an element of uneasiness but the rectal tube was barely passed beyond the sphincter. Although no attempt was made to expel the air from the tube we managed between us to coax the saline into the bowel in sufficient quantity to serve the desired purpose. In nature's own position — i.e., squating, or in the position attained on the toilet — the soft parts are drawn away from the anus, but on the bedpan the reverse is the case. I was handed the roll of toilet paper and expected — it is the custom apparently — to reach the vicinity of the anus and surrounding parts by the anterior route. For my part I was not doing very well, not having arms the length of those of an orang-outang. I suggested that I might try some wadding-like stuff that he had laid on the table but had not used for anything. This proved to be even more slippery than the glazed toilet paper. Perhaps if it were moistened it might be more efficacious — but it clung to me in rolls. Finally, I asked to be taken off the pan, turned on my side, and given a cloth, soap and water. The idea of a person wanting to actually feel clean was so novel that it apparently rendered the poor old fellow speechless.

My next experience was in sharp contrast to all the others. It is a common saying that there is an exception to every rule — and I was fortunate enough to have been waited on by the exception. His procedure was so orderly, neat and tidy, and carried out with such elegance and finish, that it may well be reported in detail.

I was turned on my side and a water-proof material measuring some 4 x 5 ft. placed in position. The rectal tube, already connected with the can containing the fluid by a tube not more than four feet in length from which the air had been expelled, was lubricated and gently inserted for several inches. The so-called high enema is a myth — any length greater than that of the rectum simply curls up within this limited space. The cushion was placed in position and I was rolled back on a bed-pan that had been warmed. The fluid was very slowly introduced and by the time 30 ounces or so were placed in the bowel I was aware of its presence, but not distressingly so. The tube was removed and I was advised to retain the fluid for a while before making any effort to expel it. I was lightly covered. After the bowels moved I was again turned on my side, the pan removed, the perineum and surroundings washed, dried and powdered, and the protective sheet removed. Afterwards, I was turned on my back and provided with the means to cleanse and dry the scrotum in case I had voided. I can assure you that anyone so handled will at the end be ready to sleep, being relieved, comfortable and clean.

A subject closely allied to that of the bed-pan is the urinal. This vessel was handed to me by male and female, old and young, experienced and inexperienced, but not a single one provided against those troublesome last drops. The male urethra is quite long and a few drops are bound to linger behind the main stream and eventually stain the clothing or bedding, giving rise in part to that disagreeable odor so commonly noticed about the bedridden. I avoided any difficulty by using cellulose wipes, which can then be left in the urinal. I would suggest that it become routine to supply such whenever this vessel is asked for.

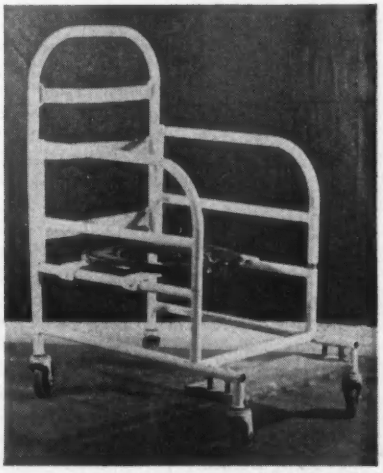
A nurse who cared for an elderly man for many years told me that there was one thing her patient's wealth was unable to buy and that was the services of a male attendant

who was willing to go beyond handing the patient the roll of toilet paper. They had tried them with and without diplomas but the one was as useless as the other. Without exception they all lacked a sense of responsibility for their patient's cleanliness and comfort.

Nothing that adds to the patient's comfort should be beneath the doctor's dignity to supervise or even demonstrate. Yet how many of our medical students have first-hand knowledge of this very important nursing procedure? The first to give me an enema was a properly qualified male nurse and he came prepared to use a solution of soap, whereas non-irritating normal saline is the ideal, or lacking that just plain water, which in my case was equally satisfactory.

It may astonish you to learn that, when the question of operation was being considered in my case, the prospect of the operation itself gave rise to little apprehension, such confidence did I have in the judgment, skill, and honesty of the surgeon. But I did worry about the almost inevitable enemas—not knowing what old soldier, furnace attendant, or handyman might be turned loose on me.

An article entitled "Revolt from the Bed-pan and Enema" appeared in *The Canadian Nurse* of September, 1949, in which was depicted a chair designed by two Swedish surgeons (translated paper in *The Lancet*, October, 1947). Such is now used in the Montreal Neurological Institute. I had our engineer at the Victoria General Hospital copy the design. A slight improvement was ordered in that provision has been made to support the patient's back when en route to the toilet. The accompanying photograph is self-explanatory. This chair has proven so satisfactory that whenever its use is ordered for one of my own patients it is invariably found to have been borrowed by another ward.



*V.G.H. Photo Dept.*

*Chair used at Victoria General Hospital, Halifax.*

It is a great comfort to a patient to be able to defecate in a more natural position and in privacy; to the fellow inhabitants of the ward, that they are no longer distressed by offensive odors; to the nurse, who is relieved from cleansing both bed-pan and patient.

It is not always easy, particularly for an older person, to sit with the whole lower limb at right angles to the body. If you take a bed-pan and place it on the floor and get on the thing you will get the idea even under this most favorable condition of rigidity. Now try it on a soft and springy mattress which permits it to sag this way or that as your weight slips slightly to right or left. Your centre of gravity must correspond to the centre of the pan — otherwise you fall in or fall out. Your weight depresses the pan deep in the mattress and, as a consequence, your heels are tilted up. This balancing act is no mean feat and would test the skill of a tight-rope sitter. It requires the expenditure of a great amount of nervous and muscular energy — sometimes more than a patient can afford. Death on the bed-pan is not uncommon.

This paper has been written with the purpose of directing the attention of the profession and those responsible for the training of nurses to the inadequate instruction given and the apparent failure to emphasize this important detail in nursing care.

# Barbiturate Acid Poisoning Treated with Modified Electrotherapy

CHARLES PINCH, M.D., C.M., M.R.C.P., F.R.F.P. & S. *and*
J. J. GEOGHEGAN, M.B., Ch.B., D.PSYCH.

*Average reading time — 7 min. 24 sec.*

BARBITURATE ACID POISONING is increasing in frequency. Emergency treatment with such preparations as metrazol, picrotoxin, and autonomic nervous system stimulants such as benzedrine sulphate, are not very successful because of their transient action and, in some cases, from the toxic action of the drug itself. It is also believed that pulmonary infection is a common sequela. Furthermore, epileptiform seizures are liable to follow the administration of metrazol and picrotoxin, thus complicating the patient's condition.

Some psychiatrists know from experience with electro-stimulation of the brain that certain electro-stimuli appear to eliminate barbiturates within a very short period of time — e.g., 14 grains of sodium pentothal administered intravenously can be eliminated within two minutes. This observation suggested the use of selected electro-stimulation in the treatment of patients suffering from over-dosage of barbituric acid or its derivatives. The following case illustrates a new method of treating barbituric acid poisoning. As far as is known this method has not been reported in the literature:

Mrs. Brown, aged 49, married, no children. The patient has always been delicate. Her husband has a pension for silicosis and this couple live on his pension of $90 per month. From the material point of view this patient has little to live for.

The patient was examined two years ago for a complaint indicative of menopausal changes. Appropriate treatment gave symptomatic relief. Five months ago she presented herself for further examination for a hemorrhagic vaginal discharge. A gynecological examination suggested a diagnosis of degenerating carcinoma of the cervix. The patient herself believed that she was suffering from cancer and was showing evidences of depression. The patient had a total hysterectomy but pathological diagnosis did not reveal any evidences of malignancy. Convalescence appeared normal but the patient left the general hospital in a depressed condition.

About the end of September, 1950, she was again requiring medical attention and it was noted at this time that she was depressed, irritable, weeping at frequent intervals, complaining of hot flushes, eating and sleeping poorly. Mrs. Brown was thin and emaciated. Estrogenic substances were prescribed and she was given a prescription of 36 x 1½ gr. capsules of pentobarbital sodium with instructions how to take them.

On October 2, the husband found his wife lying on the floor of his home at approximately 11:00 a.m. Mrs. Brown told her husband she had taken "too many sleeping pills by mistake." Within a short time she was unconscious and was removed to a general hospital. On arrival there she was stuporous, flushed, reflexes were present, breathing normal, and rousable by painful stimuli. As more than an hour and a half had elapsed since she had taken the sleeping pills, gastric lavage was useless. At this time no knowledge as to the quantity of sedation taken was available.

The patient received such preparations as coramine and methedrine and was placed in an oxygen tent. Her condition remained satisfactory with her blood pressure averaging 104/72 until 1:30 p.m. when she became deeply comatose with shallow respiration and imperceptible pulse. All reflexes, including corneal reflexes, disappeared.

Drs. Pinch and Geoghegan are associated with Homewood Sanitarium, Guelph, Ont.

Mrs. Brown was seen at 2:00 p.m. She was in deep coma; her pupils were contracted and did not respond to light; corneal reflexes absent; deep reflex absent; positive Babinski on the right side; breathing shallow; pulse imperceptible; blood pressure 88/?.

Brain stimulation was started at 2:24 p.m. The electrodes were placed immediately above the ears and a modulated electric stimulus was applied. Immediately the cardiorespiratory picture improved. Pulse became full and strong at 88 per minute and remained at this all during the treatment. The blood pressure rose to 130/76 immediately; breathing became strong and regular. The patient's general appearance became more satisfactory. There was little in the way of muscular twitching and there was little pyramidal response during the first three hours of treatment. The electric stimulus flowed continuously until approximately 5:00 p.m., the electrodes being in the same position all this time. It was noticed then that the patient's condition was gradually worsening. The treatment was interrupted for a few minutes to enable her to receive the last rites of her church. At this time her blood pressure had dropped below 80 and the original picture had re-established itself.

Electro-stimulation was commenced again but this time the electrodes were moved from place to place as it appeared evident that the patient had developed a tolerance to stimulation over the parietal regions and was not responding. Her condition again showed dramatic improvement. The electrodes were constantly moved from one position to another ranging from the bi-temporal position all the way down to the angles of the jaw. Motor response reappeared at 5:15 p.m. and at 9:30 p.m. tendon reflexes returned in rapid succession. At 10:00 p.m. the patient made voluntary movements of the hands, arms, and legs and was able to swallow sips of water. At 10:30 p.m. Mrs. Brown could be roused by oral stimulation. At 11:30 p.m. she was fully conscious and able to answer questions without confusion. The electric current had been flowing almost continuously from 2:24 p.m. until 11:30 p.m. The patient required some further medication during the night but no relapse occurred. Examination the following day revealed that despite such prolonged brain stimulation with electricity no confusion or memory loss were noted. It was later learned that she had taken 29 1½-gr. capsules of pentobarbital sodium and that she had planned suicide for some weeks.

Mrs. Brown's depression was not helped by this type of electric stimulation. She attended Homewood Sanitarium as an out-patient for electro-convulsive treatment and after two such treatments it was noted that her depression and ideas of hopelessness had disappeared. After two more electro-convulsive treatments, her mental condition was very satisfactory. Ir was noted that she had gained weight, was relishing her food, was sleeping well, and definitely was hopeful as to the future.

This case is remarkable for the following reasons:

1. The large dose of barbiturate consumed.
2. The uselessness of an important first-aid measure — the gastric lavage.
3. The prolonged and successful use of brain electro-stimulation.
4. The patient's rapid recovery following electro-convulsive treatment.

The apparatus used is known as the Reiter Electro-Stimulator, Model No. CW 47. As to the mode of action of this treatment the following opinions are suggested tentatively:

1. Cardiorespiratory stimulation (electrical artificial respiration) carries the patient along until the drug is in some way neutralized or eliminated.
2. Electric brain stimulation in some way causes the rapid elimination of barbiturate drugs from the nervous system.
3. This type of brain electro-stimulation cannot be used therapeutically without considerable pre-treatment sedation — such as five to ten grains of sodium pentothal intravenously — on account of severe pain. Painful stimulation of such an intense nature may be a factor in facilitating the return of consciousness. This patient did not complain of any pain during her treatment, although it was obvious from her response during the latter part of the treatment that consciousness to such painful stimulation was returning.

# Zephiran Chloride

MARY K. MCGRATH

*Average reading time — 19 min. 12 sec.*

ZEPHIRAN CHLORIDE is an antiseptic of high germicidal and bacteriostatic potency, constructed on an entirely new chemical basis. It contains no phenol, iodine, mercury, or other heavy metal. Aside from high germicidal properties a bactericide must possess other advantages to justify its use for preoperative skin and mucous membrane antisepsis. Of equal importance is its rapidity of action, detergent properties, penetration power, its noninjurious effect upon tissues, its wide field of application, and economy in use.

Zephiran concentrate is a watery solution of a mixture of alkyl dimethylbenzlammonium chlorides introduced by Domagk in 1935. It is a faintly perfumed, colorless, slightly alkaline fluid which froths on shaking. It gives a soap-like sensation to the skin, leaving it smooth.

Zephiran belongs to the quaternary ammonium compounds. This group of organic detergents includes zephiran, cetavlon, pheneude, and ceepyrn. These are wetting agents. They lower the surface tension of solutions containing them so that these can make intimate contact with "wet" surfaces. They probably exert their antiseptic action by interfering with the function of the bacterial cell membrane.

The method of designating the acidity or alkalinity of a solution in terms of the hydrogen ion content has been universally adopted. The hydrogen ion can vary. A strong acid solution has a nearly one hydrogen ion content. In a strong alkali it is 10-1. For the sake of convenience Sorensen introduced the symbol "pH." This is a logarithm to the base 10 of the reciprocal of the "H" ion concentration. The "pH" factor is one of the most important factors of a medium to be considered.

Most antiseptics—e.g., phenol, chlorine compounds—are effective in an acid solution. The chemical nature of the solvent present has been shown to influence the effectiveness of some germicides. Mercurochrome, for example, is of no value in water but fairly active in acetone or alcohol and is, therefore, water solvent. Many agents react with other protein materials as well as with bacteria and the presence of protein material may reduce the effectiveness. There are several proprietaries that have germicidal activity and are cationic in action and most effective at pH 9. One of these detergents is zephiran.

Zephiran, one of the large family of cationic agents, finds wide application in industry, is a very effective germicide, and has marked inhibitory action on the growth of bacteria, even in low concentrations. It is more effective against *Staphylococcus aureus* than either metaphen or merthiolate and is bacteriostatic to the spores of *B.subtilis*. Its bactericidal power is impaired by the presence of serum but only when the concentration of the latter reaches 50%. It is nontoxic and non-irritating. It is freely soluble in water, clear, colorless, almost odorless. It is soluble in acetone, alcohol, insoluble in ether, only slightly soluble in benzene. The aqueous solution is slightly alkaline to litmus. The pH is 9 or neutral. Upon shaking it foams like soap and has an acid taste.

Zephiran has a low surface tension. This factor, along with its detergent action, serves to remove dirt, skin fats, desquamating epithelium and superficial bacteria. It exposes the underlying skin to the germicide. This efficacy was demonstrated by Collins and Newman, who made full

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thickness skin biopsies taken from areas treated with zephiran 1/1000 solution. These were cultured in an effort to determine whether the antiseptic had been carried deeply into the skin structure. In the 51 samples, 49 showed no growth. In two there were growths but the organisms were morphologically altered.

While most solutions deteriorate with age and lose their potency when subjected to a range of temperatures, zephiran can be kept at room temperature for several years unchanged. Stored, frozen zephiran chloride has no loss of potency according to phenol co-efficients. Stored at 50°C. for several weeks, it shows no loss in efficiency.

Zephiran is compatible with most substances with which it is likely to come in contact. Most antiseptics are relatively incompatible with soap in that when mixed with high concentration of soap their germicidal potency and skin tolerance may be affected. Inasmuch as zephiran is a cationic agent and soap an anionic, soap should not be used with it. Zephiran inactivates the action of soap and is recommended for use on intact skin, which is generally scrubbed with soap and water preparatory to surgery.

Walter states that zephiran chloride aqueous solution for topical application possesses detergent ketolytic emulsifying properties. Tests carried out with methods accepted by the Food and Drug Administration demonstrate that zephiran chloride has high bactericidal action as shown by the phenol co-efficients for various pathogenic parasitic microorganisms. Inasmuch as official standards have been established for *Eberthella typhosa* and *Staphylococcus aureus* only, arbitrary strains with predetermined phenol resistance were selected for testing with respect to the remaining organisms. Perhaps the simplest way of determining the germicidal activity of antiseptic substances is to find the highest dilutions capable of killing bacterial cultures in a given time. Care must be taken to differentiate between bacteriostasis and actual killing power of the preparation. The following table (DUNN—*J. of Surgery and Hygiene*) shows the highest dilution of zephiran chloride capable of destroying organisms in 10 but not in 5 minutes (average values):

| ORGANISMS | 20C. | 37C. |
|---|---|---|
| *Staphylococcus aureus* | 1:20,000 | 1:35,000 |
| *Eberthella typhosa* | 1:20,000 | 1:70,000 |
| *Escherichia coli* | 1:12,000 | 1:40,000 |
| *Streptococcus hemolyticus* | 1:40,000 | 1:95,000 |
| *Streptococcus viridans* | 1:35,000 | 1:65,000 |
| *Cryptococcus hominis* | 1:24,000 | 1:70,000 |

Other reports by Hoyt show *Staphylococcus aureus* killed at 1:16,000 concentration in ten minutes.

Domagk, in his original report on zephiran chloride, demonstrated that this antiseptic is effective against almost all pathogenic organisms in greater dilution and in less time than cresol soap. The experiment consisted of the addition of 5 drops of 24-hour broth cultures to 5 cc. of the dilution of zephiran chloride to be tested. After a given time a sample was transferred to the bouillon peptone broth for sub-cultures of streptococci; for gonococci a nutrient medium, especially suited to the strain under investigation, was used and glycerin broth was used for diphtheria bacillus.

Maier reported that the germicidal range reaches up to 1:100,000 and the bacteriostatic action to 1:800,000.

In a study of the bacteriostatic action of various "wetting agents" upon the growth of the tubercle bacillus *in vitro*, Freelander reports that the most effective is zephiran chloride.

Wallace took small squares of fabric from seven suits impregnated with *Escherichia coli*, *Staphylococcus aureus*, etc. These were dried for 18 hours in order to fix the bacteria on the cloth. These were placed in various disinfectants, then washed. The tests showed that zephiran 1:10,000 destroyed the organisms in four to six minutes.

It is important that an antiseptic be capable of not only destroying pathogenic microbes but also of annihilating them rapidly. Thompson

and Isaac found that zephiran chloride destroyed staphylococcus in less than one minute. Iodine, mercurials, and silver destroy only a fraction of the organisms within five minutes.

Most spores are highly resistant to destruction by chemicals. The anthrax spore will survive in 5% phenol for from 2 to 40 days. The presence of organic matter also diminishes the sporicidal effect of a germicide. Spoulding and Deskowitz have demonstrated that instruments grossly contaminated with blood and pus infected with *B. anthracis*, *Clostridium tetani*, or *Cl. welchii* can be completely sterilized by zephiran 1:6,000 in 10-95 minutes.

Undiluted commercial concentrations of several mercurial bacteriostatic agents fail to destroy organisms in 15 minutes; whereas zephiran at 1:1,000 will destroy the same organisms in 10 minutes.

Zephiran is low in toxicity and non-poisonous. A solution of 1:25,000 to 1:4,000 is safe for use on the eye and produces no irritation when repeatedly applied to the conjunctiva of albino rabbits. A 1:1,000 solution has been given to guinea pigs for months by mouth as their only source of fluid with no effect upon their health. Six cc. of a 1:1,000 solution has been injected intraperitoneally in guinea pigs daily for several months. These animals bore litters and gained weight. Autopsy showed only areas of parietal thickening and scarification.

Walter showed that sponges soaked in a 10 per cent solution of zephiran and used as vaginal packing following curettage were non-irritating. Therefore, because of the efficiency of zephiran chloride as a disinfectant, its rapid, non-toxic, non-irritating action, it is adaptable in nearly all phases of medicine and surgery where skin and mucous membrane antisepsis is required.

Zephiran is particularly valuable as a germicide for use on the skin preparatory to surgery. There is no irritation under adhesive tape following the application of zephiran. Collins and Newman report that in 76 cases in which zephiran skin preparation was used there was one wound infection and in this case there was reasonable doubt of skin infection. In 25 cases using tincture of iodine on the skin the infection rate was 28 per cent. Cutter and Zollinger have used zephiran routinely on thyroid, knee, hallux valgus, and reconstructive operations with absolute success.

In obstetrics and gynecology, zephiran may be used on the skin and mucous membrane for disinfection. It is recommended for douches for *Trichomonas vaginalis* in a 1:2,000 aqueous solution. It does not stain clothing and prevents unpleasant odors. Zephiran removes the products of disintegration of cancerous tissue and avoids an increase of temperature often observed with the metallic type of antiseptics.

In genitourinary infections a bladder lavage of 1:20,000 is recommended. This dilution may also be used for urethral irrigations.

In the eye antisepsis a 1:2,000 or 1:3,000 solution of aqueous zephiran is non-irritating to the conjunctiva.

For disinfection of superficial wounds, 1:1,000 zephiran chloride tincture is very valuable. For deep lacerations and wet dressings a 1:5,000 solution of aqueous zephiran is applied without pain or discomfort. In 80 cases of deep and superficial lacerations at Harlem Hospital, New York, only one infection followed the use of zephiran and that was in a very deep forearm laceration.

Because of the good tolerance of the mucous membrane to zephiran it can be used in 1:1,000 to 1:10,000 solutions to irrigate antrums, throats, and in otitis media.

Following burns treated with tannic acid, patients sometimes develop infection under the eschar. It has been proven that following débridement of the eschar and application of a 1:5,000 solution of zephiran the temperature rapidly receded from 101°-103° to normal. Healing rapidly followed with healthy granulation. A solution of 1:10,000 zephiran should be used for burns in children.

Optical instruments, rubber goods,

paraffin mesh or rubber tissues, and other surgical instruments which have been thoroughly cleaned will be sterile after 30 minutes' immersion in a 1:1,000 solution of aqueous zephiran. Gloves may be kept sterile over long periods of time in a 1:5,000 solution.

Knife blades do not dull or corrode when stored in aqueous zephiran 1:1,000 for six months. However, anti-rust tablets or 30 grains of sodium nitrite and 75 grains of soda bicarbonate should be added to each quart of solution.

The ordinary method of disinfecting hands is by washing with soap and water, followed by rinsing with alcohol. The number of organisms slowly but steadily increases during the course of surgery. Particularly with surgeons who tend to perspire freely, the exudate within the gloves becomes very rich in bacteria.

Zephiran possesses the advantage that even if only traces of diluted solution adhere to the gloves or hands the growth of bacteria is inhibited. To repeat, it does not irritate the skin or make the finger-nails brittle. For surgical disinfection, after the usual soap and water scrubbing, the hands should be thoroughly rinsed with water and immersed in zephiran tincture for from two to five minutes. Hausser and Cutter demonstrated that after scrubbing the hands for ten minutes with soap and water then soaking in alcohol the cultures were 75 per cent positive. In another experiment washing for one minute in zephiran solution showed only 5 per cent positive cultures. It also has been found that the zephiran film remains active three hours after the initial application.

The usual surgical preparation of the skin is to shave, clean with soap and water, then use ether to remove any soap. Tincture of zephiran is then applied to the skin. A rosy blush will remain on the skin. However, if the soap has not all been removed, a dull orange hue will be evident.

Some orthopedists prefer a 24-48-hour preparation of the area with zephiran. The skin is shaved and thoroughly cleaned with soap, water, and ether. Dressings soaked with zephiran are then applied and held in place. These dressings are removed in the operating room and the area is again painted with zephiran. From my own experience, following 75 cases of orthopedic surgery, including open reductions, Smith-Petersen nails, etc., having this full preparation we did not have a single infection. In cases where elderly patients, particularly, had been painted with tincture of iodine, we had infections and burns following the application of adhesive. We also found that patients who were allergic to iodine could tolerate zephiran.

Zephiran may be colored or colorless. As a tinting agent for zephiran tincture, an indicator dye has been added in some cases. In acid mediums with the latter an orange-amber hue is maintained. In alkali mediums this rapidly fades to a light yellow. The intensity of the color of the skin prepared with tincture depends, therefore, upon the acidity or alkalinity of the skin. It also indicates whether all soap has been removed before the application of the antiseptic.

Zephiran is available in concentrates or dilutions. It is very economical and has found a place in every operating room.

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A nation-wide survey in the United States has shown that only 11 per cent of school-age children have had hearing tests. A case-finding program that is begun when the child enters school is too late. The profound and many lesser hearing handicaps in childhood usually occur prior to school age. Nevertheless, a case-finding program among preschool children is rare . . . Mass screening technique is not readily applicable, although testing in individual cases is reliable even at one or two years of age. For every preschool child known to have severe hearing loss there are probably 20 with milder degrees labelled mental retardation or behavior problem. The diagnostic examination is better done under the egis of a pediatrician.

— *Proceedings, 49th Annual Conference, U.S. Children's Bureau*

*Public Health Nursing*

# An Outpost Nurse in Saskatchewan

GLADYS AYLSWORTH

*Average reading time — 16 min. 48 sec.*

IN THE NORTHERN PART of Saskatchewan, back in the bush where we have neither roads nor trains and are dependent entirely upon the air service, the barge, and the radio for our contact with the "outside," a number of interesting projects are underway, helping to bring about an improved standard of living for the people. There are new schools in many communities and the teachers are well qualified and enthusiastic. Demonstration gardens are being grown in many places, under the supervision of the Department of Agriculture. Natural Resources representatives are available to look after such local matters as the issuing of hunting licences, the clearing of the furs which the trappers bring in, the observation and fighting of forest fires in the summer, and the collection of certain data and weather information for departmental study.

The attention of the provincial Department of Public Health has been focussed on this area, too. As part of an extensive program, the department is operating four small outpost hospitals, each one staffed by a nurse-midwife, a housekeeper, and a caretaker. The oldest of these is at Cumberland House. It has been in operation for a long time but the other three have all been built within the last five years. There is one at Sandy Bay, 60 miles from Flin Flon, another at Stony Rapids on Lake Athabaska, and one at Buffalo Narrows, near Churchill Lake, 200 miles from Prince Albert.

These are modern, sunny, two-storey buildings, painted white with green roofs. Each has hot and cold running water, electricity and a radio. We are well equipped to meet the local needs and to maintain a high standard of nursing care. In the patients' wing, there is a dispensary-clinic room, a bathroom, two bedrooms, three beds, extra folding cots, a child's bed, and cribs and baskets to hold several babies. On the same floor, the nurse has her own apartment. It includes a living-room, her bedroom, the guest room, and a bathroom. It is pleasingly furnished with articles chosen for the most part by the nurse in charge. The local organizations provide the little luxuries. The housekeeping department is downstairs. It consists of the laundry room, a storeroom, a kitchen-dining room, the housekeeper's room, the furnace room, and the wood room. In one of the hospitals, the housekeeper has a cosy sitting-room off the kitchen.

My friends were amazed when they heard I was planning to come out here. "Whatever has got into you anyway?" they asked. "You have no idea what it'll be like. You know it's winter there most of the time and you'll surely freeze. There won't be a soul but you and the Indians and the Eskimos." These solicitous folk shook their heads when I refused to seek the advice of a psychiatrist. They solemnly predicted that, sooner or later, I would be torn limb from limb by the wolves — the four-legged ones — that roam the northland during the long winter nights. In spite of many dire warnings, I came with my hopes high and have not been disappointed. I have not been bored, nor lonely, nor subjected

Miss Aylsworth is nurse-midwife at Buffalo Narrows, Sask.

to any unusual hardships. And I have no fear for my personal safety so far as the wild life is concerned.

I am posted at Buffalo Narrows and have as many friends here as I have the time to visit — people whom it is a pleasure to know. We are not isolated. We always have the radio and the air ambulance services available to us for emergency use. We get our mail every week and it is surprising how quickly the day comes around and catches us unawares. Every mail plane brings at least one letter from the department and often a news item of medical interest. The barge visits the community once a week in summer and the trucks come in on the ice regularly after "freeze-up." We always look forward to seeing these visitors for they bring us up-to-date on all the news from "outside."

Last year I spent the summer months of July and August at Stony Rapids, 75 miles south of the Northwest Territories, and found the weather delightful. After nine o'clock in the evening it would be cool enough to wear a jacket but during the day the temperature ranged in the high 70's and 80's most of the time. During the one hot spell of the season, the mercury soared to the 90's.

It was July 1, 1950, when I went to Stony and I was fascinated by the length of the days at that season. We had no real darkness — only about an hour and a half of deep twilight around midnight. I came home from a dance at 1:30 one morning and looked through the trees at the bright red sunrise shining on the water and heard the birds already singing their early morning songs. About an hour later, after the dance wound up, the men got together and played a game of ball before they went to bed.

Dancing was very popular. The school was always available for the purpose and anyone who wanted to "get up" a dance had merely to obtain the key from the caretaker and speak to the musician. Then someone would shoot off a pistol twice, a prearranged signal of invitation to all the people at Stony Lake, two miles away. The occasion might be someone's birthday, the arrival of the barge, or perhaps a week-end guest. There was usually a good turn-out at these functions and the local people did some very pretty folk dances — the Handkerchief Dance, Drops of Brandy and Schottische. The musician was an Indian lad of some 20 years who played a guitar and at the same time a mouth-organ which he held in place by means of a specially constructed framework that extended over his shoulders. Sometimes he would beat time for us with his foot.

There are gardens at most of the hospitals, the success of these undertakings varying, of course, with soil conditions, the type of "year" we have, and the strength of the local fences. I was very proud of the one which was left for me when I came to Buffalo Narrows. There had been a colorful array of lovely flowers all summer long and we picked the last two bouquets of pansies on October 26, the day we dug up the beds and changed the earth.

There was an abundance of vegetables too. We more than filled the potato bins and had several bags each of parsnips, beets, carrots, and turnips. We had a good crop of corn and all the ears were large and well filled. In one picking we gleaned 192 cobs and later picked as many more. We stored in the local refrigeration plant, for our use during the winter, corn-on-the-cob, peas, beans, spinach, broccoli, cauliflower, cranberries and blueberries. We do not envy our city friends the varieties available to them in the great city stores.

I enjoy working with my patients very much. The majority are Treaty Indians and Metis, with only a few white people. Perhaps the most interesting phase of our whole program is the maternity work. Our preparation for this type of care includes a six months' course in midwifery at Maternity Centre Association, New York, which each nurse takes before assuming charge of one of these outpost hospitals. Abnormalities in obstetrics are rare in this part of the country, due, in part, to the fact that the people live simple lives, get plenty of exercise,

and are of a placid nature. Dr. Read, in his "Natural Childbirth," can teach them nothing for they already know the art of relaxation. We do not perform episiotomies and rarely do we get a tear. I had the thrill of delivering an 11-pound baby without any injury to the mucous membrane. We provide prenatal care among the white women, too, and some of them prove excellent candidates for the Read Method of Natural Childbirth.

We have numerous out-patient calls. Every day people drop in complaining of all sorts of things — a toothache, a burn, a cough, a scratch, diarrhea, or an injury sustained on the trap-line. The Indian people are, by nature and training, very reserved and shy. They do not talk freely with us and often bring along an interpreter whose chief function, so far as I can see, is to keep them company.

Sometimes they come alone and talk by signs. They are skilled dramatists and, although they generally put their ideas across very well, we sometimes fail miserably in understanding them. One time a mother came in to me, shoving ahead of her a sullen little 8-year-old with a dirty scarf tied over the lower half of his face. No one spoke at all during the interview but the mother kept poking at his face, his mouth, his abdomen. Then, for emphasis, she would prod me to watch her while she put her head to one side and rested it on her hands. The child himself, whenever I glanced at him, would claw his face and incline his head and put his hands under his jaw as his mother did. At once I suspected toothache and reached to uncover the child's face but his mother jerked my hand away. Apparently I hadn't got the point. I was playing a game of charades and getting the worst of it. Finally an interpreter put me straight. It seems the child was suffering from upset stomach. The kerchief was tied over his mouth in case of accident (an excellent idea to remember in times of bush flying). The constant attention to the side of his face suggested the need to lie down and the poking at the child's abdomen indicated the source of his trouble.

Time is also found for public health service in the settlement. We give the school children health inspections, immunize them and do the necessary follow-up work. The preschool children and infants come to the office for their health supervision. From time to time we have dental health clinics, VD clinics, Tb. surveys, and tonsil clinics and make individual arrangements for special care such as eye examinations. Thus we manage to meet the needs of the local people quite well.

Generally speaking, the idea of preventive medicine has not yet penetrated. The Indian does not possess the attitude of the Irishman who proudly asserted that he always took medicine when he was well and consequently never got sick. These people have unlimited faith in the white man's "madsin." In almost every case, poor nutrition and poor health habits aggravate an illness and impede recovery. Sickness in the home makes the Indian feel helpless and panicky.

The habits of these people demonstrate that the psychological value of "mothering" is a potent force in the struggle for survival. Granted, the death rate is high among Indian children but a study of their living conditions would indicate the reason for it. Many of them live in cold, drafty houses all winter, or occasionally in tents, without the benefit of nutritious food or regular habits of eating or sleeping. The school children are poorly clothed.

The Indian women cuddle their baby almost constantly from the time they are born. They rarely leave them to play by themselves and they feed them every time they cry. When the mothers are not holding their babies in their arms, they put them in swings. Every home has a swing, made of two ropes strung side by side across the room with a pouch construction of old blankets half-way across its length for the baby to lie in. Each time the busy mother passes by, she gives the swing a push and sets it in motion. When she takes her baby anywhere, she bundles it in a mossbag and ties it to her back.

Her baby is laced in so tightly that it almost bulges over the top. The bag is filled with dried moss which keeps it warm and absorbs the moisture. In many instances the moss is changed far too infrequently. The little Indian children sorely miss all these personal attentions when they have to come to hospital.

Once I admitted a 2-year-old child with severe diarrhea and bloody stools. I was very busy just then and had the mother undress it for me. When I returned in a few minutes she had gone and left the child lying quietly in bed, a nipple in its mouth and a fresh apple in its hand.

It seems natural for these women to love all babies — other people's as well as their own. I had an out-patient waiting her turn outside the clinic door one afternoon. She heard a child crying in the ward. She slipped down the hall, picked it up and held it till I had time to get to it.

While these people are very stoical in the face of real pain and can endure severe hardships without a murmur, they tend to make the most of their minor complaints.

Generally speaking, our contact with the Indian has not mellowed him. Those who have spent many years among the native people — the missionaries, social workers, and business men — feel that we never quite win their complete confidence. We do not persuade them to accept our way of life nor our ideas of thrift and economic stability. One white man who is married to an Indian woman told me that, originally, he had hoped to make a white woman out of her but, instead, she had made Indians of him and their children.

These people share one another's property, money, and food with complete abandon. Whenever they feel hungry, they go and find something to eat. They live predominantly in the present without any of the white man's concern for the future. When a fairly heavy, unseasonal snowstorm struck us late in September last year, I don't believe there was one Indian child with a pair of shoes. They all went about as usual — barefoot. Consequently, during the weeks that followed, the hospital was filled almost beyond capacity with sick children who suffered from high temperatures, upset stomachs, and heavy colds.

Buffalo Narrows is more influenced by the pressure of civilization than some of the other places. There is a population of about 300 and we have a fish filetting plant, two hotels, three stores, two restaurants, two churches, and a 3-room school. We also have movies twice a week. The people have studied our ways and become shrewd in their dealings with us. They can drive hard bargains.

Our annual bazaar was a great success. We had several tables of pretty things for sale, a fish-pond which the children loved, and a very attractive tea. The Indian customers hung around the second-hand counter all evening and priced every article over and over again. Some of them argued that we were charging too much and asked us to reduce our prices. We watched a little girl come up and buy a large white purse and a woman's broad-brimmed hat to match. It took all her money to pay for it and she went away looking very proud. Before long she was back again. She had just retailed her newly acquired finery down at the hotel at a nice profit and was on the look out for a few more saleable articles. A little later on a man came in and bought a second-hand sweater which he resold almost at once. He kept returning from time to time all evening, flushed and happy with each new success.

Subject matter for the amateur photographer is almost unlimited around here. The Indian people, as is well known, have a great love of art and possess a lively color sense. They display their talent in the lavish clothes they wear — their jackets, moccasins, belts and gloves which they decorate with great patches of beautifully bright beadwork and embroidery. Everyone, even to the youngest runabout child, has a handmade parka, fashioned with exquisite care, usually fringed along the yoke and sleeves, trimmed with fur around the face and embroidered all over with

beadwork. These parkas are really very fine and many white people take great pride in wearing them, too. These things and the red plaid shawls the women wear in the summer, the bright dresses, the pipes in their mouths, and the embroidered moss-bags hanging down their backs add interesting local color.

I recorded with my camera a picture of a bridal party at Stony who went around calling in the community on their wedding day. The groomsman wore his best leather jacket, the groom a navy blue suit several sizes too large, and the bride, happy creature, was decked out in the community's traditional bridal gown, made of curtains turned yellow with many wearings. A lace curtain served as her veil and her long black hair was decorated with numerous little ribbon bows — red, green and blue. Her brown cotton stockings hung in rolls over the tops of her moccasins. Two of the attendants took advantage of their visit to the hospital to have medical consultations before they left.

Another scene worth photographing is to follow the fishermen out on the lakes in winter and watch them dig holes in the ice and set their nets underneath. The photographer would find it very cold out there away from the sheltering trees and hills. He would have to wear his heaviest fur-trimmed parka to keep from freezing his face. He would get a picture of the men hauling out their nets, filled with squirming fish hanging in the meshes by their gills. His camera would fail to catch the breathless excitement with which everyone waits and watches the nets being lifted out on the ice. If he stayed late enough he might help fry the supper over the little box stove in the caboose. Probably he would taste that rare delicacy — fried fish livers.

During the winter, life in the north is more exciting for all of us. With the first snowfall, out come the snowmobiles (known as "snowbugs" or simply "bugs") — those great, powerful vehicles on skis that plough through the heaviest snow and consume gasoline at the rate of six miles to the gallon. At the same time, a dozen dog-teams appear, hitched to long, low sleds, their bells jingling merrily all over the village.

We like to listen to the retired bushmen who sit around of a winter evening, telling about their adventures on the trap-line. These bushmen are hale and hearty, with large muscles and keen weather-beaten faces. Some of them are people of good education and many are widely travelled. All have undergone a levelling process and emerged "bushed." They will tell you of the winters they have spent out on the trap-lines, making their rounds and sleeping in the cabins along the way. These people have spent many years in the north. Some of them take the occasional holiday outside but the others have no wish to leave at all. To the newcomer, they seem garrulous, fanciful, and unkempt. But their warning to us is that if we come back here and stick it out for more than a year or two, we will probably join their ranks and become with them "white Indians."

# In Memoriam

**Alice Wilken Potts Chezzie,** a graduate of Kingston General Hospital, Ont., died in Toronto on May 31, 1951.

**Mrs. Mabel Emma Evans, R.R.C.,** who served overseas with C.A.M.C. during World War I, died at Cowichan Station, B.C., on June 2, 1951, in her 73rd year.

**Bertha Ellen Hall,** who graduated in nursing in Portland, Oregon, and served overseas during World War I with the U.S. Army Nurse Corps, died in Victoria on June 5, 1951, aged 70 years. From 1924 to 1929 Miss Hall was assistant superintendent of the Victorian Order of Nurses for Canada.

*Aux Infirmières Canadiennes-Françaises*

# L'Hôpital en Face d'un Etat d'Urgence National

J. H. Roy

LES ENGINS DE GUERRE modernes menacent aujourd'hui les populations civiles d'une dévastation dont l'ampleur ne trouve d'égale nulle part dans l'histoire. La guerre au moyen de la bombe atomique, des produits biologiques et des gaz, nécessite, sur le plan civil, une forme tout-à-fait nouvelle de mobilisation dans laquelle nos hôpitaux doivent assumer des responsabilités d'envergure.

Etre prêts à faire face à toute situation critique, émanant d'un sinistre national, constitue à l'endroit de nos administrateurs d'hôpitaux et de leurs collaborateurs — en plus des autres tâches nombreuses qui les assaillent — un problème d'une importance vitale. Et, pourtant, l'hôpital doit être prêt à toute éventualité. C'est là un de ses caractères essentiels, et les problèmes que suscitent une préparation adéquate, doivent être attaqués avec détermination, et résolus à la lumière de plans rigoureux.

La défense civile est un organisme complexe qui nécessite la participation de plusieurs organisations et leur coordination parfaite, selon un plan bien défini. Elle requiert — à chaque échelon: fédéral, provincial ou municipal — la participation active de l'autorité civile. De nombreuses commissions de ces trois formes de notre gouvernement étudient actuellement le problème vital de la défense civile en vue d'élaborer un plan-directeur. Un tel plan donnera, de toute évidence, des directives bien tranchées à tous nos groupements et définira clairement les responsabilités de chacun dans la sphère qui lui est propre. D'ici à ce que de telles directives soient tracées, les hôpitaux ne peuvent se préparer en vue d'un état d'urgence que d'une façon nécessairement limitée. Comment, en effet, les hôpitaux pourraient-ils commencer à accumuler des fournitures médicales ou à augmenter le chiffre de leur personnel, quand la rareté de la main-d'oeuvre et du matériel rendent, avec le manque d'argent, de telles mesures impossibles? Tout hôpital peut, cependant, à l'heure actuelle, organiser les ressources qu'il a en main et apporter au programme d'ensemble de la défense civile une importante contribution que ce dernier assimilera éventuellement.

Cette étude se limitera donc à décrire brièvement les mesures qu'ont adoptées individuellement certains hôpitaux et à énumérer les suggestions mises de l'avant par les autorités civiles, en regard des préparatifs nécessités par un état d'urgence éventuel. Je rappelle tout d'abord que les recommandations et les suggestions que je vous soumets ne sont pas le fruit de mon expérience personnelle. Elles ont été puisées largement dans les manuels préparés, tant par le gouvernement américain que par le gouvernement canadien, et s'inspirent de l'expérience acquise par ceux qui ont mis à l'essai les plans qu'ils avaient édifiés en marge d'un désastre prévu. En période d'urgence, l'hôpital devra:

(a) Recevoir les victimes.
(b) Donner les soins d'urgence.
(c) Assurer le traitement des blessés qui requièrent des soins continus.

M. Roy est surintendant de l'Hôpital St-Luc, Montréal.

(d) Déterminer les patients dont l'état permet leur évacuation à domicile ou aux endroits désignés à l'avance.

(e) Pourvoir aux soins des patients, non victimes du sinistre, et que leur état critique retient à l'hôpital.

Tout hôpital peut augmenter sa capacité normale et admettre un très grand nombre de victimes, au moyen des trois mesures suivantes:

(1) En congédiant et en évacuant, au moment d'un sinistre, les patients dont l'état le permet. (On estime qu'environ 75 pour cent des patients pourraient ainsi libérer l'hôpital.)

(2) En limitant aux seules personnes sérieusement blessées l'admission à l'hôpital.

(3) En augmentant, enfin, le nombre de lits de l'hôpital. A cet effet, on mesurera soigneusement tout l'espace disponible pour ajouter des lits additionnels au sein de l'hôpital même, de la résidence des infirmières, et de tout autre édifice s'y prêtant, situé dans le voisinage de l'hôpital. L'emplacement des lits ordinaires et des lits surnuméraires sera illustré sur un croquis avec lequel devra se familiariser le personnel dirigeant de l'hôpital. Les services d'urgence seront établis dans les endroits qui se prêtent à une bonne circulation. Des panneaux-indicateurs de la direction à suivre seront fabriqués à l'avance, pour être installés, au moment opportun, à l'intérieur et à l'extérieur de l'hôpital. L'admission et l'évacuation des victimes devront marcher de pair. Ces manoeuvres simultanées seront rendues possible en affectant l'entrée réservée aux ambulances à l'admission des victimes et en ménageant, pour leur évacuation, une porte de sortie située dans un autre endroit de l'hôpital.

On devra former des équipes préposées au triage des victimes et établir un système nécessaire à leur identification. On épinglera, à cette fin, sur chaque patient une fiche sur laquelle seront inscrits les renseignements recueillis sur son identification, la nature de ses blessures, et un résumé du traitement institué. Un service pourvoyant au transport et à l'évacuation des patients sera organisé et sa direction sera confiée aux représentants de l'administration. Le personnel médical devra travailler en étroite collaboration avec l'administration.

### A L'HÔPITAL

Le manuel publié sur la défense civile propose certaines méthodes à suivre pour diriger avec efficacité les victimes admises à l'hôpital. Voici quelques suggestions:

Dans le cas d'un hôpital de quatre étages, par exemple, on réservera la majeure partie du premier plancher aux patients souffrant de choc ou d'hémorragies, dont l'état nécessite des soins immédiats. Une partie du deuxième plancher pourrait être affecté au traitement des brûlés. Si les salles d'opération sont situées au troisième étage, les victimes de blessures par traumatisme seront logées sur ce plancher. On aménagera enfin dans l'hôpital une quatrième zone pour les patients atteints de la maladie des radiations et pour ceux dont l'état critique rend toute évacuation impossible. On recommande d'agrandir l'espace réservé aux salles d'opération et d'y ajouter des tables de traitement. Il est entendu que l'accès aux salles d'opération sera limité aux seuls cas de chirurgie majeure; on prendra soin des lacérations et des cas mineurs de chirurgie dans le lit même des patients, sans avoir à les déplacer.

Si, pour une raison quelconque, la Croix-Rouge n'est pas en mesure de fournir les énormes quantités de sang requises — ce qui est à prévoir — on devra organiser une banque auxiliaire de sang dans un endroit favorable; le département de physiothérapie, par exemple, se prêterait bien à ce service. Dans tous les cas où la chose est possible, le choix des donneurs de sang, de même que celui des aides bénévoles, se fera à l'extérieur du centre hospitalier même.

Les services préposés aux renseignements ou chargés du personnel établiront leurs quartiers dans les édifices en bordure de l'hôpital. Dans le but d'éviter la confusion, on placera en faction à chaque porte de l'hôpital des gardiens qui en prohiberont l'accès à toute personne dépourvue de raisons valables. Les parents et les amis des victimes seront dirigés vers un centre de renseignements établi en dehors de l'hôpital, tel que mentionné précédemment. Le bureau d'administration s'occupera de fournir à ce centre des informations concises mais complètes quant

aux noms et à l'état des victimes.

On établira de plus, dans un endroit à l'écart, un service auxiliaire de morgue. On procédera à une évacuation rapide et discrète des morts.

### Le Personnel Médical

Le directeur médical de l'hôpital assumera la direction de la défense civile et procèdera à l'organisation et à l'entraînement des équipes médicales. Il partagera les responsabilités d'un chacun en marge d'un état d'urgence et définira les fonctions de chaque membre du personnel médical ou de tout corps professionnel affilié à ce dernier. Le directeur médical, ou son remplaçant, sera responsable de tout ce qui a trait aux soins médicaux. Son autorité sera absolue dans ce domaine et il pourra, selon le cas, assigner les médecins aux endroits où leur présence semble le plus nécessaire. Ces chefs devront se consacrer entièrement à leurs devoirs de surveillance et de direction et devront, si possible, s'abstenir de donner eux-mêmes aucun traitement aux patients.

Le chirurgien-en-chef, ou son remplaçant, assumera la responsabilité des équipes chargées du soin des brûlés et de celles préposées au soin des victimes de traumatisme, des équipes d'anesthésistes, et de celles assignées aux salles d'opération

Le chef-pathologiste, ou son remplaçant, veillera au fonctionnement des services de laboratoire, de la banque de sang, et des services connexes. La tâche d'organiser les services de radiologie incombera au radiologiste-en-chef.

Les plans élaborés en prévision d'un état d'urgence devront grouper chaque médecin dans une des équipes déjà mentionnées et lui fournir des directives détaillées sur ses devoirs et ses responsabilités.

Les services de pharmacie devront concentrer leurs efforts à la préparation et à la distribution des médicaments d'urgence; on prendra les dispositions nécessaires pour assurer un service de 24 heures par jour.

### La Section du Nursing

Le manuel publié aux Etats-Unis sur la défense civile recommande de confier l'élaboration des plans du nursing, en vue d'un état d'urgence, et la responsabilité de sa mise à exécution, à la personne qui dirige, en temps ordinaire, la section du nursing.

En temps normal, les différents services où s'exerce le nursing lui confèrent des appellations habituelles de nursing en médecine, en chirurgie, en pédiatrie, etc. En période d'urgence, ces dénominations seront changées et chaque service du nursing sera désigné par la catégorie des blessés à laquelle il s'adresse et prendra les noms de service du nursing des brûlés, des malades, des radiations, etc.

### Bureau d'Affaires

Pendant une époque de désastre, le bureau d'affaires de l'hôpital prendra charge de la comptabilité, des dossiers médicaux, des statistiques se rapportant aux patients, des services d'approvisionnement, du fonctionnement du service de communications, etc. Certains travaux de documentation essentielle devront être effectués par l'archiviste. Parmi ceux-ci, on note:

(1) L'enregistrement des patients; le soin de classifier les fiches de traitement et d'identification recueillies à la morgue de l'hôpital; l'établissement d'un service de renseignements relativement aux patients sous traitement et à ceux qui ont été congédiés ou transportés ailleurs; (2) le soin des dossiers de malades qui ont été transférés; (3) des rapports que le surintendant de l'institution doit soumettre aux autorités compétentes.

### Service de Diététique

Le service de diététique de l'hôpital s'occupera de nourrir les blessés, le personnel, et les aides bénévoles. Les menus habituels seront modifiés et la variété en sera restreinte. On utilisera le plus possible d'aliments en boîtes, conserves, etc. En règle générale, on discontinuera la préparation des diètes spéciales, des pâtisseries, des salades. On ne placera, dans le cabaret du malade, que le strict nécessaire au service. Le manuel recommande d'utiliser, autant que possible de la vaisselle en papier. La possibilité d'être privé des services d'utilité pu-

blique doit être prévue. Il faudra prendre les mesures en conséquence. Le gaz, l'électricité, et l'eau peuvent manquer. On devra, en certains cas, improviser des méthodes de cuisson temporaires. On pourra, à cette fin, utiliser des boîtes métalliques de bonne dimension et des feuilles de métal étendues au-dessus de feux à ciel ouvert.

### Services Techniques et Service d'Entretien

On recommande, comme indispensable pour ces services, un plan détaillé sur papier. Immédiatement après un sinistre, le personnel de ces sections procédera à un examen rapide des édifices pour déceler la présence de dommages ou en apprécier l'étendue. Les approvisionnements ordinaires d'eau peuvent être coupés; en prévision d'une telle éventualité, les mesures nécessaires devront être prises en vue d'assurer à l'hôpital d'autres sources d'approvisionnement. Des dispositions adéquates seront également prises en vue d'éviter tout gaspillage d'eau.

### Travaux de Ménage

On utilisera, avec avantage, dans les services de nursing et de diététique, le personnel préposé aux soins du ménage car ces employés connaissent bien l'hôpital. Les travaux de nettoyage seront alors confiés à des volontaires.

### Service de Buanderie

Les quantités nécessairement limitées de draps, serviettes, et articles analogues, obligeront peut-être le service préposé au lessivage à fonctionner 24 heures par jour. Si l'on vient à manquer d'eau ou si celle-ci n'est pas disponible en quantité suffisante, on confiera les travaux de lessive à une buanderie située à l'extérieur de l'hôpital.

### Approvisionnements

Le manuel recommande aux hôpitaux d'augmenter de 20 pour cent leur réserve habituelle d'approvisionnements. Les mesures suivantes ont été suggérées, comme essentielles, dans toute bonne organisation pour parer à un désastre:

Adopter une méthode rapide et sûre pour rappeler à l'hôpital les médecins, les infirmières, les infirmiers, les téchniciens, les préposés à l'administration, à la cuisine, aux travaux de ménage.

Mettre les patients de l'hôpital au courant du désastre survenu.

Choisir des chefs; n'en nommer pas trop car le rendement en souffrirait.

Distribuer des fiches d'identification au personnel de l'institution.

Renvoyer de l'hôpital tous les visiteurs.

Procéder à un triage rapide des patients. Diriger vers un endroit spécialement aménagé les cas de blessures mineurs et réserver pour les grands blessés les salles de traitement.

Adopter un système simplifiant l'enregistrement des blessés.

Assurer la progression continue et sans heurt des patients vers les salles d'opération.

N'admettre dans les salles d'opération que les équipes de chirurgie.

Charger une personne qualifiée des communiqués destinés à la presse et à la radio.

Confier, par l'entremise du chef du nursing, des fonctions bien déterminées à chaque garde-malade dès son arrivée à l'hôpital.

Cet exposé, tel qu'énoncé précédemment, ne constitue aucunement un plan de défense civile. Il est plutôt une esquisse brossée à grands traits, pour rappeler que les hôpitaux doivent se consacrer à des études sérieuses de leurs ressources et de leurs disponibilités, afin qu'ils soient prêts à être assimilés plus tard dans le plan d'ensemble que proposera notre gouvernement.

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Almost the entire population of Canada is affected by tooth decay and gum disease, members of the Canadian Public Health Association were told in Montreal. Dr. Hugh R. McLaren, assistant chief of the Dental Health Division, Department of National Health and Welfare, termed this situation "the most extensive public health problem confronting the community today."

— *Canadian Press*

*Institutional Nursing*

# The Story of Anesthesia

G. H. STOBIE, M.D., F.R.C.S., F.A.C.S.

*Average reading time — 11 min. 48 sec.*

THE USE OF anesthetics to alleviate the pain of surgical operations and of childbirth was unknown before the middle of the 19th Century. Prior to that time the "anesthetic" consisted of strong men and ropes. No greater boon has ever come to mankind than the power to induce a temporary but complete insensibility to pain. So far as surgery is now concerned, the means of inducing anesthesia are highly developed and extremely effective. Such is not the case in childbirth. Certain conditions, partly physiological and partly sociological, have prevented the use of anesthesia from being developed and applied to the same extent that has attained for surgery.

The discovery of anesthesia for surgical operations was first demonstrated with the use of ether in 1842 by Dr. Long, a general practitioner in Athens, Georgia. Years ago they used to have "ether frolics" in Ireland, where they would inhale the ether and get quite a "jag on." Some of the young men in Athens were having one of these ether frolics and Dr. Long observed that some of them went to sleep. They seemed to be insensible to pain when they would bang their shins or fall over a chair or table in their frolic.

He employed ether in surgery on a man by the name of James Venables, put him to sleep in his back office, and removed a wen from his neck. The paid receipt for $2.00 for operation and anesthetic is still preserved. He did a few other operations but made no public announcement of it. No general development of ether as an anesthetic can be attributed to Long. Nevertheless, he was appreciated by the citizens of Georgia. Just recently a marble statue of him was dedicated and placed in the rotunda at Washington.

Wells, a dentist in Boston, tried ether in 1845 for the extraction of teeth. He became allied with a Dr. Morton, who was a graduate in medicine and had also studied dentistry. They were improving the method of making plates and along with this development they studied ether anesthesia. Prior to that time, plates were fitted over the snags of decayed teeth. They found that by giving ether and pulling the teeth they could make the plates fit much better. Morton became the promoter. He persuaded Dr. Warren at the Massachusetts General Hospital to allow him to give a demonstration at the hospital on a patient who was going to have an operation. Warren was very skeptical but he invited several doctors to see the first surgery under ether. It was a success and Dr. Warren after the operation said, "This is no humbug."

This success did not depend on the employment of a new drug but a new method of administering it. Anesthetics are inhaled and therein lies their special feature. The action of a drug which is swallowed cannot be controlled once it passes into the body. Its effects diminish only as it is slowly eliminated during hours or even days. On the other hand, the action of the vapors of gases which are used as anesthetics continues fully only as long as these substances are

Dr. Stobie practises in Belleville, Ont.

inhaled. When the inhalation ceases they are rapidly exhaled and their action can thus be accurately controlled.

The narcotic action of such drugs as opium, hemp, and mandrake has been known from antiquity but these drugs cannot be used satisfactorily as anesthetics. They deaden pain but they also exert a depressing influence upon the action of the heart and respiration which, if the dose is large, may result fatally. Moreover, pain partly conteracts the action of narcotics. Thus when given in the large amounts necessary to relieve the pain of the operation, they may prove poisonous when the operation is over and their effects are no longer neutralized by the pain.

The surgery of the pre-anesthetic days depended largely upon speed. An operation verged on being a sleight-of-hand affair designed to shorten to the minimum the suffering of the surgeon's victim. We read of Ambrose Paré, that great French surgeon, amputating a thigh in the twinkling of an eye, and Langenbeck, surgeon general to the Hanoverian Army in the time of Napoleon, amputating a shoulder while one might take a pinch of snuff.

The word "anesthetic" was not in use prior to Morton's demonstration in 1846. Immediately following it, when that great scholar and physician, Oliver Wendall Holmes, was asked to suggest a name, he replied with the word "anesthetic," to define the substance used to produce insensibility, and the word "anesthesia" for the state of insensibility. Morton joined with a Dr. Jackson and tried to commercialize anesthesia but they were very much criticized by the profession for their unethical conduct. There followed for many years a very bitter struggle between Wells and Morton who soon dissolved partnership, each trying to prove his claim as the originator of the use of ether as an anesthetic.

Morton petitioned Congress for a reward for his discovery. In 1854, a bill was before the Senate for its final reading (to grant $100,000 to Morton) when Senator Davison arose and stated it had been brought to his notice that ether had been used by Dr. Long in Georgia for a surgical operation four years before Dr. Morton's demonstration. In consequence of this declaration, the appropriation was allowed to die.

This agitation in the United States, to reward the originator of anesthesia, was brought on by the world-wide attention that was being directed to Glasgow, Scotland, where James Y. Simpson, the professor of obstetrics at the University, had begun using chloroform extensively as an anesthetic for the relief of the pain at childbirth. The Americans became apprehensive lest they should be robbed of the honor of the discovery. Simpson first used ether but found difficulties in its use, particularly on account of its odor and irritating action. He then, with his colleagues, Duncan and Keith, examined a great number of chemicals in the hope of finding a substitute for ether. They adopted chloroform as the most promising possibility. There is an account of the three of them gathered in Simpson's dining-room. On the table were three tumblers of chloroform. They sat and inhaled the fumes from these glasses. They became exhilarated, a lively conversation ensued, and then the three suddenly fell asleep. Soon after this experiment in 1847, Simpson used chloroform to relieve the sufferings of a woman during childbirth.

Of the first case in which chloroform was used Simpson writes:

> The lady to whom it was first exhibited during parturition had been previously delivered in the country by perforation of the head of the infant, after a labor of three days' duration. In this, her second confinement, pains supervened a fortnight before the full time. Three and a half hours after they commenced and ere the first stage was complete, I placed her under the influence of chloroform. The child was expelled in about 25 minutes, after the inhalation was begun. Some minutes elapsed before she awoke. She observed that she had enjoyed a very comfortable sleep and, indeed, required it as she was so tired, but could now be more

able for the work before her. In a little while she remarked that she was afraid her sleep had stopped the pains. Shortly afterwards her infant was brought in by the nurse from the adjoining room. It was a matter of no small difficulty to convince the astonished mother that the labor was entirely over and that the child presented to her was really her own living baby.

Simpson immediately published his success with chloroform but the result was not an acceptance of this means of relief. It precipitated a violent controversy over the propriety of abolishing the pains of childbirth. A lesser man than Simpson would have been crushed by the intense opposition he encountered but Simpson enjoyed a fight in a good cause.

It is an historical fact that, in 1591, a lady of rank, Eufome Macalyene, sought the assistance of Agnes Sampson for the relief of pain at the time of the birth of her two sons. Agnes Sampson was tried before King James for her heresy, was condemned as a witch, and was burned alive on Castle Hill, Edinburgh.

The Scottish clergy arose again in the 19th Century, if not to burn Simpson with fire, at least to consume his practices with their fiery condemnations. But Simpson, less submissive than the lady of the 16th Century, turned and with their own weapon of religious interpretation silenced the clergy and cleared the way for the more serious controversy with the men of the medical profession.

The clergy of Scotland denounced the use of chloroform in childbirth from the pulpit, and by pamphlets. Many otherwise sensible people were thus led by their religious scruples to doubt the propriety of inhaling chloroform. The arguments used by the clergy varied but all centred around the theme that pain, particularly the pain of childbirth, was the ordained lot of women. To prevent it was a sacrilege. As one clergyman expressed it:

> Chloroform is a decoy of Satan, apparently offering itself to bless women, but in the end it will harden society and rob God of the deep earnest cries which arise in time of trouble for help.

Another pointed out that chloroform, like alcohol, produced intoxication and unconsciousness, and on this slender foundation rose to rhetorical heights. He drew a picture of the lying-in room with its former quiet dignity, now giving way under the influence of chloroform to a scene of drunken debauch during which a child was brought into the world. The authority claimed for these ecclesiastical attacks lay in the biblical curse placed upon mankind (*Gen III: 16*):

> Unto the woman He said, I will greatly multiply thy sorrow and thy conception; in sorrow thou shalt bring forth children; and thy desire shall be to thy husband, and he shall rule over thee.

It was the portion "in sorrow thou shalt bring forth children" which was the crux of the matter. According to their interpretation, pain (sorrow) was ordained in childbirth and the prevention of pain during childbirth was contrary to religion and the express command of Scripture.

Simpson replied to these accusations in a series of papers which, for their theological skill and sound logic, left little to be said against the use of chloroform. He was a busy practitioner and his writing was done in snatches, even at the bedsides of women while attending them in confinement. One can easily visualize this staunch Scotsman writing some of his passages with a sympathy and a conviction that arose from the groans of his patients.

(*To be concluded next month*)

The infant is no mere digestive tube as pediatricians used to assert in the heyday of feeding schedules but is a being with a mental life, both intellectual and emotional, capable of increasingly differentiated reactions to both favorable and unfavorable atmospheres.

— LUCIEN BOVET, M.D.

# Psychometric Testing Techniques

HELEN ERSKINE

*Average reading time — 10 min. 12 sec.*

A SURVEY WAS MADE in Canada to determine what testing techniques are employed by Canadian schools of nursing. The survey was begun by contacting, by correspondence, the directors of the various provincial registered nurses' associations. In many cases, the association was able to state definitely which hospital training schools were employing psychometric testing techniques. The hospitals were then written to directly for more detailed information regarding their programs. With the exception of Quebec and Ontario, the number of training schools in each province is small and it was felt that the above method was adequate for the purposes of this survey.

The 30 French hospitals in Quebec were not contacted on the grounds that selection in these hospitals presents a somewhat different problem to that confronting the training schools of Canada as a whole, most of the available testing devices being standardized on English-speaking populations. Moreover, although the large number of schools is impressive, only three of the 30 training centres enrolled more than 50 beginning students in 1948.

In Ontario, where nursing education was under the control of a government department, the Nurse Registration Branch of the Ontario Department of Health, the desired information was not obtainable in the central office. However, a list of the 63 training schools in the province was obtained, together with the enrolment of each. A questionnaire with regard to psychometric testing devices used was sent out to each training school having an enrolment of 100 students or more. Of the 16 schools contacted, 13 replied. The three schools not replying were comparatively small training centres having enrolments of 146, 133, and 121 students. One school, being in conjunction with a specialized hospital, gives most of its training service by affiliation with other hospitals.

Further information was obtained through the National Office of the Canadian Nurses' Association in Montreal. Figures were obtained regarding the total student enrolment in the hospital training schools of Canada, the rate of withdrawal from a class (the one graduating in 1948), and a break-down of the reasons for withdrawal. An attempt was made to discover if any study had been done on the intelligence test scores of student nurses since Weir's survey in 1932 but no such study has been made — at least, not on a national level.

This survey of conditions in Canada has revealed widespread interest in psychometric testing of student nurses. Although a certain amount of scepticism has been expressed, the dominant feeling seems to be that better methods for the selection and guidance of students are needed and, in consequence, the possibilities of psychological tests are being seriously considered. Lucile Petry, in connection with her hospital survey in British Columbia, pointed out their importance.

*British Columbia:* Of the six schools of nursing there, in only one is any kind of psychometric testing done. The Vancouver General Hospital gives the Otis-Self-Administering Test of Mental Ability to each student one month after admission to the school of nursing. The tests are administered and interpreted by a member of the Bureau of Measurements of the Vancouver School Board. The class me-

This material formed part of a thesis prepared in conjunction with Miss Erskine's post-graduate study in psychology at the University of British Columbia during 1949-50.

dian is calculated and compared with that of Vancouver Junior Matriculation students. The median I.Q. of some classes in recent years has been as low as 108.9 and as high as 117, with an average of approximately 113. These results are encouraging when compared with Dr. Weir's findings in 1932. The testing program in this hospital has been in effect for the past 16 years.

*Alberta:* There has recently been expressed a desire to institute a province-wide project of giving intelligence and personality tests to nursing students entering the various schools. However, at the present time, of 11 training centres, only two have employed psychometric devices.

The Royal Alexandra Hospital in Edmonton has been using the Psychological Examination for College Freshmen (A.C.E.).The instructors administer the test to the students and also score them. Spelling and arithmetic tests are also given. Previously, a Silent Reading Test was given but proved of little value. The present program has been used for recent preliminary classes and its value in guidance is thought to be questionable. The need for testing before entrance is recognized and the desire to experiment with a greater number of tests is expressed. The reason stated for not making greater use of the tests is because of a sense of inadequacy in dealing with them. The need for expert interpretation of test results is felt.

The only other training centre in Alberta employing a testing program is the Holy Cross Hospital School of Nursing in Calgary. Here, they have used the battery of the Psychometrical Service Co. of Canton, Ohio, for the past four terms. The tests are given to the preliminary students after entrance and are used for guidance purposes. Mr. Dent, test consultant of the Psychometrical Service Co., administered the first battery himself and since that time the tests have been given by the science instructor. The company interprets the tests and returns a full report on each student to the school.

*Saskatchewan:* Of 10 schools of nursing, two employ psychometric testing devices. The Regina Grey Nuns' School of Nursing and St. Paul's Hospital School of Nursing, Saskatoon, employ the battery of the Psychometrical Service Co. It is felt that the tests are excellent in showing the weaknesses to be found in the preliminary students and are felt to be invaluable in the teaching program. They are not, however, used as selection devices.

*Manitoba:* Here, eight of the 11 schools of nursing replied to a request for information. Of the eight schools only two are using any formal tests. One other is currently seeking advice with respect to tests which they might use. One school began giving tests to the students in 1947. The tests are given in a block during the students' first week in the school. Professor Williams, of the Department of Psychology of the University of Manitoba, has cooperated in giving the tests and also a member of the Board of Education of Winnipeg. The American Council on Education Psychological Examination and the Iowa Silent Reading Test are used. No mechanical dexterity, personality or emotional adjustment tests have been tried. In the other school employing testing devices, the Wechsler-Bellevue Intelligence Test has been used. The school does not feel that it is an "ideal" test for nurses but has found that the general knowledge acquired in this way about each student is helpful in understanding that student.

*Ontario:* Of the 16 schools contacted, 13 replied. Of these, only three are using any sort of testing devices. Four hospitals expressed a desire for information regarding the availability, cost, etc., of tests now in use in other schools of nursing.

The Hospital for Sick Children, Toronto, has used the following tests in its school of nursing:

1. Kuder Preferences Record.
2. Moss-Hunt Aptitude Test for Nursing.
3. Otis Test of Mental Ability.
4. Bell Adjustment Inventory.
5. Health Education Test Grade 7-12 and College Form A.

Most of these tests had been in use

up to five years previous to the last war. At that time the practice was discontinued due to a lack of personnel to evaluate the tests properly. When in use, the tests were used in research in conjunction with the school's opinion as to the suitability of the applicant to enter the field of nursing but the results were unsatisfactory due to a lack of cooperation on the part of the students. Since that time, the tests have been used only when there is some doubt as to the advisability of accepting an applicant and this use of the tests has proven satisfactory. Health Education Tests are given to all students shortly after entrance in order to acquaint the school with the students' knowledge of health education.

The Victoria Hospital School of Nursing, London, has made a start in the psychometric testing of their student nurses. The majority of the testing has been conducted by the Department of Psychology of the University of Western Ontario and the tests have been of their selection. They have been using the following tests:

1. Otis Quick-Scoring Test of Mental Ability — Gamma Test.
2. Study Habit Inventory.
3. George Washington Series Aptitude Test for Nursing.
4. George Washington University Pre-Test Arithmetic for Prospective Nurses.

When this paper was prepared no data were available regarding the value of the tests. It is hoped that at a later date they might be used for both selection and guidance purposes.

St. Joseph's Hospital School of Nursing, Toronto, is using a Health Education Test, "Knowledge and Application," published by the Acorn Publishing Co., Rockville Centre, New York, but employs no other testing devices.

*Quebec:* Of the seven English-language schools of nursing, only two have employed psychometric tests to any extent. In these schools, such tests have been administered only after the admission of the students to the school.

The Queen Elizabeth Hospital School of Nursing in Montreal has employed a testing program for preliminary students for some time. The tests are administered by a consulting psychologist who is a member of the Department of Psychology at McGill University. The tests used are the following:

1. Otis Self-Administering Test of Mental Ability.
2. Kuder Preference Record.
3. Humm-Wadsworth Temperament Scale.
4. Achievement Tests in Vocabulary, Arithmetic, and General Science.

The test results are used by instructors to give special help and guidance to certain students who are shown to require it. Much interest is expressed in the program. It is hoped that definite results will be shown in the future through its use.

The school of nursing of the Royal Victoria Hospital in Montreal employed the services of the Psychometrical Service Co. The director of nursing stated that events since the testing have proved that the psychometric examiners "were not 100 per cent correct" in their estimates of the students and feels that high school grades and a personal interview yield sufficiently reliable indications of the ability of the student.

*New Brunswick:* The hospitals are just beginning to organize testing programs in their schools of nursing. At the Moncton Hospital, through the cooperation of the Moncton High School vocational guidance instructor, Intelligence Tests (Otis) were done on all 1949 students. The testing was done for the purpose of evaluating the mental capacity of the preliminary student as a guide in the selection of that group. No other tests were employed. At the Victoria Public Hospital, Fredericton, intelligence testing of the three preliminary classes has been carried out by a member of the Psychology Department of the University of New Brunswick, using the Clapp Young Self-Marking Test.

*Nova Scotia:* None of the 15 schools of nursing is using any kind of psychometric tests for either the selection or guidance of their student

nurses. The enrolment in the Nova Scotia schools of nursing is relatively small.

*Prince Edward Island:* The Charlottetown Hospital School of Nursing is the only school to employ psychological tests. Here, the battery of the Psychometrical Service Co. is used. No candidates were accepted who were not recommended by their results on the tests. Hence, the Charlottetown Hospital bears the distinction of being the only training school for nurses in Canada which gives a test battery a major place in the selection of its student nurses.

## In the Good Old Days

(*The Canadian Nurse*, September 1911)

"A great many children are swallowing bacteria with every meal because they have no tooth-brushes with which to clean their teeth. Because parents, either through poverty or negligence, do not fulfil their responsibility in this respect, it is all the more reason why others, who are in a large measure responsible for these children, should attend the more carefully to them. In Toronto, the school board supplies tooth-brushes at a cost of five cents each to all children who haven't any in their homes."

* * *

"Some effort should be made through popular magazines and the public press to give the public a proper view of the work nurses do. A committee might be appointed to prepare articles relating to public health and nursing problems for such publication."

* * *

"A summer uniform has now been adopted. Early in June I suggested short sleeves and a collarless uniform to replace the turned-up sleeves and loosened collar which persisted in confronting me during our hot weather, in spite of all my efforts to prevent. The suggestion was received with delight. The uniform consisted simply of utilizing the more worn uniform waists, by cutting the sleeves off above the elbow, forming a box pleat to take up the fullness and finish by stitching on, firmly, a two-inch cuff of white linen. The collar was removed and a circular band of white stitched on to correspond with the cuffs. This makes a very attractive and comfortable uniform and lends economy in several ways. The old uniform is made to wear several months longer. The cuffs and collars are laundered on the waist thus saving much washing, starching, ironing, and sorting each week. The nurses are delighted with their new-found comfort and can heartily recommend this innovation to other schools."

"In the Royal Victoria Hospital, Montreal, a new men's surgical ward is being opened, thus bringing to 64 the number of beds available for this service. A wing containing 20 private rooms is being added to the hospital. This will bring up the number of private rooms to about 70. These changes will, of course, necessitate additions to the nursing staff."

* * *

"Regina's splendid new General Hospital has been opened. It is one of the best equipped in Canada and will accommodate 125 patients. The roof garden will provide a comfortable resting place in the fresh air for convalescent patients."

* * *

"It is often said that ours is a 'nation of dyspeptics.' Medical men appreciate how apt this statement is and never was there a time when it was more true. One of them remarked recently, 'People are living so fast today that they do not stop to masticate their food.' The things people eat are censored to tickle the palate, rather than nourish and build the body. The consequence of such pleasurable and improper eating is a disordered stomach."

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A child's code of behavior, based purely on an equilibrium of pleasure and reality principles, will result in social difficulties, for he will give way without further thought to a particular pattern of behavior once he has made certain that no unpleasant consequences will result. Adolescents who think they must not steal, only because they might be caught by the police, are examples of emotional development arrested at this stage.
— *Psychiatric Aspects of Juvenile Delinquency, World Health Organization Monograph.*

# Trends in Nursing

THE EXECUTIVE COMMITTEE of the Canadian Nurses' Association appointed at its last meeting a special committee to prepare a plan for nursing in a national emergency. The committee has now met and has prepared the following plan for mobilization of nursing service resources. The plan was approved by the Sub-Executive of the C.N.A. and has been released for the information of the provincial nurses' associations.

## Plan for Mobilization of Nursing Service Resources

National security and civil defence have become matters of the utmost concern to the people of Canada today. In any plans formulated for the maintenance of essential services, nursing will be considered a vitally important occupation requiring certain measures of control in the mobilization and distribution of personnel, as well as an increased supply of nursing service.

Through foresight and coordinated effort, the Canadian Nurses' Association hopes to be prepared to meet, with the least possible disruption of present nursing service, any emergency that may arise. It also hopes to provide a maximum efficiency for all civilian requirements, as well as for the future needs of the armed forces, by maintaining a sound educational program to meet these commitments.

To this end, a special committee was formed to prepare a statement of policies and a plan of action designed to provide for as adequate nursing service as possible under total defence planning.

### GENERAL PRINCIPLES

Planning for general mobilization of nurse power should be in terms of an overall plan designed to meet nursing service needs for military, defence, and civilian purposes; such a plan should be sufficiently flexible to provide for quick re-allocation in the event of a major disaster in Canada or in another country to which health services must be sent.

A most important factor will be the setting up of a broad educational program to ensure an adequate and continuing supply of nursing personnel in all categories.

Distribution of nursing resources will be accomplished most economically and with least disruption if made a responsibility of the nursing profession.

### RECOMMENDATIONS

Steps shall be taken to:

1. (a) Determine existing nursing service resources through a nation-wide registration of trained nursing personnel: (i) graduate, (ii) auxiliary—both practising and inactive; (b) determine existing nursing service needs; (c) estimate nursing service needs in the event of national or international disaster.

2. (a) Accelerate the recruitment of men and women to meet nursing needs; (b) coordinate local and regional recruitment efforts into a nation-wide plan.

3. Training programs shall be subjected to study for the purpose of ensuring that the preparation of nursing personnel is such as to protect the health and to provide the best possible nursing care for the total population.

4. Centralization of training programs shall be studied in order to ensure the most economic use of facilities and personnel.

5. Selected nurses shall be encouraged and assisted to take advanced courses to ensure properly qualified instructors, supervisors, administrators, etc., in adequate numbers.

6. Provision for financial assistance, or increased financial assistance, should be sought for the development of all approved training programs.

7. Consideration shall be given to the setting up of periodic refresher courses of instruction for inactive nurses.

8. Vigorous action shall be taken to promote the team concept in nursing, to ensure wise, safe, and economical use of nursing resources.

9. Nurses withdrawn from civilian

practice for military service shall be selected as far as possible to fill positions for which they are prepared.

10. Regional boards of nurses shall be organized as indicated, with governmental authority to advise in the assignment of nurses to the armed services and, in the event of total mobilization, to organize the distribution of nursing personnel on the basis of priorities for essential civilian as well as military needs.

11. In the event of total mobilization, widespread publicity shall be given to the necessity for the understanding and full cooperation of the general public, of physicians, hospitals, and public health authorities, in any plan for rationing and re-distributing nursing service.

12. Equal recognition and privileges shall be given to nurses assigned to civilian and military services, in regard to educational and future employment benefits.

## State Aid for Trained Nurses

An editorial has just reached our desk from the *Moncton Daily Times*, entitled "Now, it's State Aid for Trained Nurses." Dr. L. O. Bradley, executive secretary of the Canadian Hospital Council, in an address to the Maritime Hospital Association, is quoted as having said, "The problem of nursing shortage cannot be solved without some new avenue of financial assistance other than patient fees." The avenue Dr. Bradley would tap is the treasuries of the various provincial governments, which he terms the logical source of help. Continuing his plea for the much-needed financial aid, he added:

> It is a political axiom that governments do not move until they are sure their course of action has majority approval. So far, public opinion has not been sufficiently mobilized to impress provincial governments with the need of taking action in this particular sphere.

The members of the nursing profession who have been endeavoring for years to inform the general public on these matters are grateful, indeed, to all those who give not only their support but who use their influence toward securing financial assistance for nursing education.

## General Secretary's Field Trip

The general secretary has recently returned to headquarters after attending several provincial annual meetings in western and eastern Canada. She reports great activity on the part of all provincial nurses' associations. Nursing is definitely on the march. Despite the many obstacles which confront nurses, there is encouraging evidence on all sides that they are assuming great responsibility in trying to meet the many and varied demands being made upon them today.

A new generation of young and capable nurses has grown up in the very few years since the last field visit was made by the general secretary. "They know where they are going and are just as enthusiastic about nursing as their predecessors. The future still looks bright," said Miss Hall.

# Orientation et Tendances en Nursing

Le Comité Exécutif de l'Association des Infirmières du Canada a nommé, lors de sa dernière réunion, un comité spécial, chargé de préparer un plan concernant les infirmières en cas d'état d'urgence nationale. Voici le plan approuvé et communiqué aux associations provinciales.

### Plan Concernant la Mobilisation et l'Utilisation Rationnelle du Personnel Infirmier

La sécurité nationale et la défense civile sont des questions intéressant actuellement tout le monde au Canada.

Dans tous les plans préparés pour le maintient des services essentiels au bien-être de la population, les services du personnel infirmier sont reconnus comme de première importance. En cas d'urgence la demande de service sera grandement accrue. Un certain contrôle devra être exercé sur la mobilisation et la distribution du personnel infirmier.

Il est donc nécessaire de bien connaître dès maintenant les ressources dont le Canada dispose, en personnel infirmier.

Grâce à la coordination des efforts et à la prévoyance, l'A.I.C. espère pouvoir maintenir les services de santé déjà en existence, tout en répondant aux demandes suscitées par un état d'urgence. L'on espère pouvoir répondre aux besoins de la population civile et aux besoins futurs de l'armée en maintenant un programme équitable de recrutement et d'éducation.

*Principes généraux concernant la mobilisation du personnel infirmier:* Dans un plan de mobilisation l'on doit considérer la totalité des ressources disponibles, les besoins de la population civile et de l'armée, et ceux créés par l'état d'urgence. Le plan doit avoir une flexibilité, permettant la rédistribution du personnel en cas de désastre dans un endroit du Canada ou dans un autre pays où il est nécessaire d'envoyer de l'aide.

L'A.I.C. considère qu'une plus grande économie sera réalisée si cette distribution est laissée à la profession d'infirmière.

*Recommandations:*

1. (a) Par un enregistrement national déterminer les ressources du personnel infirmier qualifié: (i) infirmières (ii) auxiliaires—en service actif ou retiré; (b) déterminer les besoins actuels au point de vue service infirmier; (c) déterminer en cas de désastre, national ou international, les besoins au point de vue service infirmier.

2. (a) Accélérer le recrutement chez les hommes et les femmes susceptibles de prêter leur aide dans le domaine des soins infirmiers; (b) coordonner sur un plan national tous les efforts de recrutement.

3. Le programme devra faire l'objet d'étude spéciale; le but à réaliser est de protéger la santé et de donner les meilleurs soins possible à toute la population.

4. La possibilité de centraliser les centres d'entraînement devra être étudiée afin d'utiliser avec le plus d'économie possible le personnel et les locaux.

5. Afin qu'il y ait un nombre suffisant d'institutrices, de surveillantes, et d'administratices qualifiées, des infirmières choisies avec soin devraient être encouragées à faire des études supérieures.

6. Une aide financière devrait permettre la réalisation d'une programme d'entraînement.

7. Pour les infirmières retirées du service actif, des cours de perfectionnement devraient être donnés.

8. Travailler à faire accepter l'idée du travail d'équipe en nursing.

9. Les infirmières retirées de la pratique civile pour le service dans l'armée devront en autant que possible occuper des postes pour lesquels elles ont reçu une préparation.

10. Des comités régionaux devront être formés, dont les membres seront des infirmières, lesquelles seront autorisées par le gouvernement à faire des recommandations concernant le nombre et la qualité des infirmières devant abandonner la pratique civile pour se joindre aux forces armées. En un mot, en cas d'une mobilisation totale, ces comités seront chargés d'assurer une distribution équitable du personnel infirmier afin de répondre aux besoins de la population civile et de l'armée.

11. Advenant une mobilisation totale une grande publicité devra être faite afin d'assurer une entière coopération entre le public en général, les médecins, les hôpitaux, et les services d'hygiène publique.

12. En cas d'urgence ou de désastre, les infirmières employées soit à la défense civile soit aux forces armées devraient bénéficier des mêmes privilèges.

## ℞ *Chuckles* P.R.N.

Intussuseption is the T.V. of one part of the bowel into another.

Hernia is the protuberance of the viscera of an organ through the opening of an orifice.

Answers on a pharmacology paper included references to "dehydrated alcohol" and "mercy bichloride".

After sponging the lower limbs one cares for the gentiles

Articles should be removed from the sterilizer with sterile biceps.

Care should be taken to prevent any further taxation of the already damaged heart.

Phenobarbital is given to lessen the nerves of a patient.

Side-boards are used to keep the bed warm by preventing draughts.

# Annual Meeting in Saskatchewan

Preceding the annual meeting on May 24, 1951, 50 superintendents of nursing and instructors met in the Hotel Saskatchewan, Regina, to discuss mutual problems. The Educational Policy Committee of the S.R.N.A. organized the meeting which was under the chairmanship of Miss Gertrude James, educational director of the Saskatoon City Hospital.

During the morning a symposium was held on "Improving Nursing Education through Affiliation." The moderator was Miss Ethel James, Regina, while the following gave short addresses followed by general discussion: Miss Dorothy Code (Moose Jaw) — Affiliation in Public Health. Miss Matilda Diederichs (Moose Jaw) — Affiliation in Rural Hospitals. Miss Margaret Callbeck (Regina) — Affiliation in Psychiatry. Miss Catherine Lynch (Fort Qu'Appelle) — Affiliation in Tuberculosis.

A sociodrama was presented by a group of nurses from Saskatoon, entitled "Improving Nursing Education through the Nursing Team." This was much enjoyed and brought forth comment and discussion.

In the afternoon Dr. D. G. McKerracher, director, Division of Psychiatric Services, Department of Public Health, spoke on some proposed changes that are to be made in the program of affiliation in psychiatric nursing.

The remainder of the afternoon session was devoted to round-table discussion on problems and their possible solutions.

ISABELLE E. LANGSTAFF

The 34th annual convention of the Saskatchewan Registered Nurses' Association was held in the Hotel Saskatchewan on May 25 and 26, 1951. All sessions were presided over by Miss Isabelle Langstaff. Co-hostesses were the Moose Jaw and Regina Chapters. Registration totalled 190 nurses. Special guests present were Miss Gertrude Hall and Dr. Pauline Jewett.

That the year had been a busy and an eventful one was indicated in the various committee and chapter reports.

In her presidential address, Miss Langstaff dealt with trends and developments in nursing education in the province. She specially mentioned the effects, as she visualized them, that would be forthcoming from bringing our nursing students from under the control of the Minimum Wage Board and placing them under the Department of Public Health. She named these as being:

1. The maintenance of our schools of nursing as educational institutions, with emphasis on the student's program of education, rather than on nursing service.

2. Attracting students who are interested in nursing as a profession, rather than as a job with monetary gains. A hospital conducting a school of nursing, with high educational standards, will attract the right type of student.

3. Maintenance of high standards in nursing education will also mean that our graduate nurses will continue to be accepted on a level with other professional nurses, not only in other provinces but in other countries.

The report of the secretary-registrar noted the Open-Shelf Library which has been placed in the new Medical Library of the University of Saskatchewan. The fact that any book available for loan outside the library may be borrowed by our members is evidence of a greatly extended use of books.

Through the generosity of the provincial government, money has been made available to schools of nursing to purchase new equipment. An additional $50 was given to each of the 10 schools of nursing to provide needed books in the libraries.

Through the Federal Health Grant money was again provided for bursaries for postgraduate education in public health nursing

while from provincial funds came bursaries for study in teaching, supervision, and administration. Money from the Dominion-Provincial Youth Training Grant has continued to provide financial aid to needy students in schools of nursing. It was noted that this year all of the grant for nursing students was used.

Some of the other points mentioned in the report were Civil Defence, work with volunteer agencies, the new edition of the "Recommendations Relating to Nursing Personnel," the Institute in Remedial English conducted by the S.R.N.A., and the work that has been done in relation to separate budgets for schools of nursing.

In the report of the adviser to schools of nursing, presented by Miss Hazel Keeler, three needs were set forth which we must aim to accomplish:

1. Better prepared clinical teachers, supervisors, and head nurses.
2. Well planned ward teaching programs in order to better assist students to use their knowledge in meeting nursing situations.
3. Extension of affiliation for nursing students.

Following the business session of the first morning, Brig. P. C. Klaehn, former Joint Civil Defence Commissioner for Saskatchewan, spoke on "Thermal and Radiation Effects of an Atomic Bomb Explosion." This address was of such vital interest that the nurses requested that Brig. Klaehn make a copy available to all those present. Provincial office undertook to do this when Brig. Klaehn graciously stated he would be delighted to have copies distributed.

The special luncheon meeting of chapter delegates, presided over by Miss Langstaff, was a stimulating meeting. Miss Hall and Dr. Jewett were special guests. It is anticipated that a meeting of chapter delegates will become an annual feature.

A panel discussion on "Mental Health — Through the Nurses' Eyes," led by Neil Agnew, M.A., executive secretary of the Canadian Mental Health Association, Saskatchewan Division, was an outstanding event of the convention program. Its organization provided for active participation by all those attending. Those on the panel itself were: Dr. D. G. McKerracher (Regina), Miss Margaret Callbeck (Regina), Miss Myrtle Crawford (Regina), Sister M. Irene (Prince Albert), and Miss Lorena McColl (North Battleford).

The three standing committees met on Saturday morning. The Public Health Committee dealt with "Affiliation in Public Health Agencies for Graduate and Undergraduate Nurses," the Private Nursing Committee with "Trends and Developments in Private Nursing," and the Institutional Committee with "Problems and Projects in Institutional Nursing." This latter committee also discussed the 1950-51 provincial project on the "Study of New Drugs." The nursing student delegates attended a special session under the chairmanship of Mrs. Nora Street. At this session Miss Dorothy Washington, speech therapist, Mental Health and Cerebral Palsy Clinics, Regina General Hospital, spoke on "The Defective in Speech."

The latter part of the morning was spent in a tour of Regina General Hospital to view the many additions to that institution.

Dr. J. M. LeBoldus, Regina, spoke on the last afternoon on the work of the Canadian Arthritis and Rheumatism Society, Saskatchewan Division. He was followed by Miss Gertrude Hall who gave an outstanding and thought-provoking address on "Looking Ahead with the Nursing Profession."

Social events were not forgotten during the annual convention. On May 25, three 32-passenger chartered buses took the nurses to the sanatorium at Fort Qu'Appelle for a delightful outing. The arrangements made by the Qu'Appelle Valley Chapter, Dr. and Mrs. John Orr, the Anti-Tuberculosis League, and the nursing staff at the San will long be remembered. A no-hostess luncheon was held on the last day of the meeting.

A ballot was sent to all members prior to the annual meeting. Those elected to office on the S.R.N.A. Council for the coming year were: Miss Isabelle Langstaff, president; Miss Dorothy Code, first vice-president; Sister Hildegard, second vice-president; Miss Grace Motta, councillor. Committee chairmen: Private Nursing, Mrs. Gertrude Robertson (Regina); Institutional Nursing, Miss Agnes Campbell (Prince Albert); Public Health Nursing, Miss Louise Miner (Prince Albert).

LOLA WILSON
*Secretary-Treasurer and Registrar, S.R.N.A.*

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**To Get Rid of Ants** — Dissolve two tablespoons of alum in three quarts of boiling water. Since alum dissolves very slowly, suggest this solution be allowed to stand overnight. In the morning, reheat solution and apply generously with dish-mop or brush.

# Dermatitis Among Nurses

W. SCHWEISHEIMER, M.D.

*Average reading time — 8 min. 36 sec.*

OCCUPATIONAL DERMATITIS is the most common form of occupational disease. Recent statistics have shown that approximately 65 to 70 per cent of all occupational diseases are skin infections. This is of considerable economic importance. Estimates by leading authorities have indicated that the average loss of the working person's time due to occupational skin disease is 10 weeks.

Nurses are subject to many of the same risks as doctors from contact with patients and also from soiled bed-clothes, excreta, and antiseptics. The incidence of skin disease in these professions is high despite the use of rubber gloves and other protective measures. There are few occupations where there is such close contact with other people, particularly with sick persons. Drs. Schwartz, Tulipan, and Peck mention a long list of possibilities for occupational diseases of the skin applying to nurses. Here are some of their important observations:

Pricks from hypodermic needles and trauma from surgical instruments lead to pyogenic infections. Mycotic infections, impetigo contagiosa, and pediculosis are occupational risks. Extragenital syphilis may be contracted from diseased patients. These lesions occur chiefly on hands and fingers. Tuberculosis verrucosa may be contracted from external sources. However, the incidence of tuberculosis in any form is not greater in these occupations than in the general population.

Dermatitis among nurses, due to sensitivity to disinfectants, is fairly common. Weak solutions of mercuric sublimate are sources of irritation, as are creosote, arsenic, iodine, lysol, chlorine, alkalis, acids and silver nitrate solutions. Burns occur not infrequently during the sterilization of instruments. Contact with hydrogen peroxide may cause skin eruptions.

Dr. Schweisheimer resides in Rye, New York.

Children's nurses are exposed to greater risks than those who attend adults, due to their closer contact with the patients. Syphilis is a special hazard. Multiple skin carbuncles, tinea circinata, erysipelas, impetigo contagiosa, pediculosis, pyoderma, and blennorrhea may also be contracted while attending young children.

In disinfecting stations, fumes of formaldehyde, sulphur, and other substances produce irritation of skin and mucous membranes. Carbon tetrachloride, which is often employed as a delousing agent, is a skin irritant. The wearing of rubber gloves when handling irritant chemicals and diseased tissues or while touching infectious skin is an effective protective measure against skin injury.

Occupational dermatitis in the majority of cases affects the hands and forearms. Pain is rare but itching common and unpleasant. It spoils the sleep and diminishes the working efficiency.

## INDIVIDUAL SENSITIVITY

Some nurses are sensitive to materials to which most other individuals are not sensitive. There are frequent instances of nurses being allergic to primrose plants in the sick room. Sensitivity may not be present at first but may develop when contact with the material is continued for a long time. It may take years until dermatitis develops.

Nurses can develop an allergy to iodoform, iodine or other substances after years of undisturbed use. Sensitivity to skin disease depends not only on the materials used and the working conditions but also on the condition of the skin itself. Sometimes changes of the skin, associated with aging, play an important part. Generally it may be said that a thin and dry skin, with a low fat content, favors the occurrence of occupational eczemas.

Modern methods of examination enable us to find out whether a nurse

is allergic to a particular material she has to handle. The patch test gives evidence of sensitivity. These skin tests are becoming more important from day to day. It is now universally accepted that the patch test, if properly performed and interpreted, is a valuable diagnostic measure.

Often the treatment of occupational skin diseases must start with a cessation of work. Most nurses try to avoid this interference with their duties. In many cases a decided improvement is seen as soon as the injurious substance has been recognized and removed. Cleanliness and wearing of rubber gloves are important aids in avoiding occupational dermatitis.

### Soaps

The cleansing qualities of good soap make it helpful in battling disease. Dr. H. E. Morton, University of Pennsylvania School of Medicine, has reported on the action of soaps in freeing the skin of microorganisms. The skin not only serves as a mechanical barrier to the entrance of germs into the body but also destroys many bacteria. The beneficial action of washing has long been recognized in surgery where "scrubbing up" is the standard sterilizing procedure before operations. By this method many microorganisms are removed mechanically.

Walker has stated that thorough washing of the hands with the formation of a good lather with any ordinary soap is sufficient to destroy any adhering diphtheria bacilli, streptococci, pneumococci, meningococci, influenza bacilli, and spirochaetae pallidae. Typhoid bacilli are affected to a lesser extent and staphylococci showed themselves much more resistant. Streptococci were shown to be susceptible to the action of yellow household soap. Colebrook and Maxtel have observed that refined toilet soaps and soft soaps have much less germ-destroying power than coarse soaps.

Medicinal or medicated soaps are those to which antiseptics or other therapeutic remedies are added. Medicated soaps are used more in Europe than on this continent. Mercury bichloride is a constituent of these fortified soaps; in stronger concentration it is irritating to many. Tar soaps are the most popular. Some people are sensitive to tar, even in small concentrations. Some compounds, such as mercuric iodide, are bactericidal when incorporated in soaps. Many other materials lose their germicidal effectiveness in the presence of soap and may even decrease the natural antiseptic properties of soap. Soaps containing cresylic or carbolic acid are less antiseptic than either soap or cresylic or carbolic acid alone when used in the same concentrations.

### Radio-Epidermitis

Radio-epidermitis or actinocutitis is an inflammation of the skin resulting from exposure to roentgen or radium rays. Nurses employed as x-ray technicians may acquire such dermatitis after a number of years. Despite protective measures, the cumulative effect of repeated short exposures becomes effective. During the early radium era such occupational dermatitis was frequent. It has diminished since we have been better informed about the dangers of those powerful rays.

The first signs are a reddish-violet color of the fingers (the thumb is seldom affected), with a sensation of fullness and sometimes of dryness. The skin on the dorsa becomes thickened and unelastic, the hairs may fall or break off. The nails become fragile and show longitudinal striations, often breaking off piece by piece. Telangiectatic and hyperkeratotic areas appear on the skin. Ulcers often occur when the horny patches become detached and enlarge without any tendency to granulation. The ulcers usually become cancerous although the process is very slow, the malignant growth appearing only after many years.

The quality of radiation, the dose administered, the interval between the various irradiations, and the individual susceptibility of the skin are responsible for the degree of radio-epidermitis. The prognosis depends on

the degree of the skin injury. The milder types of actinocutitis usually resolve without permanent damage to the tissues. The prognosis of the third-degree and chronic kind is unfavorable.

As for the treatment, Schwartz, Tulipan, and Peck consider the usual treatment for dermatitis venenata as suited in the less severe forms of occupational dermatitis from roentgen rays, while in painful and persistent cases such measures may only produce exacerbation. A lead and opium wash, with or without the addition of a powder, glycerin, or boric acid or a mixture of this lotion and carron oil in equal parts, is recommended.

For deep-seated ulcers, surgery of the necrosed tissue and skin grafts may be necessary. The whole leaf of the cactus, *Aloe vera*, applied over the ulcer is sometimes used. The under surface of the leaf is removed so that the jelly-like content which contains the active therapeutic agent may spread over the lesion. Fresh leaves are applied every 12 to 24 hours. Pain is usually relieved in 24 hours and healing takes place within two to three weeks.

## New System of Education Planned

The Regina Grey Nuns' School of Nursing has, with the appreciated assistance of their hospital medical staff, planned to inaugurate a block system of education beginning this month.

Under the block system, applied in its strictest form, a group of students is given classroom instruction, only, for given periods, while the remainder of the students during these periods receive only clinical instruction and practical experience on the hospital wards. The groups or classes rotate so that at the end of their training period all will have received the required types of instruction.

In order to keep the students in touch with the hospital nursing service, however, we plan to use a modified block system. The group of students attending classroom lectures will at the same time spend 2½ hours daily on wards. The hospital nursing service will be made more stable than is possible when student nurses are continually leaving the wards to attend lectures.

A look at the class schedules for the term shows that the new system will add considerably to the work of the teaching staff and is designed solely for the benefit of the student nurses.

As far as the students are concerned the advantages of the block system are numerous. The student nurse is relieved of ward responsibilities for the period of classroom instruction and should, therefore, be able to attend classes with a free mind. She will be rested and in a better position to arrive for classes at the specified time. It will, for example, eliminate for the student who has been on night duty the necessity of rising at 1:00 p.m. for a lecture. There will be that continuity in the classes which cannot be obtained when a subject is taught only once a week over a long period.

The block system has proven very successful in other nursing schools. Nothing is being left undone to ensure that it will also be a success here and give entire satisfaction to all concerned: the student nurses, the instructing staff, and the hospital medical staff.

SISTER A. LEVASSEUR, B.Sc.
*Educational Director.*

## ℞ *Chuckles* P. R. N.

For the patient who is tired of a restricted diet — tell them if they had all the things they'd like to eat they'd be too sick to want to eat anything.

Talkative patients should be placed next to a person with a foreign language.

A diabetic patient should be the cleanest person on the street because he doesn't know when he may go into coma or shock and have to be taken to the hospital.

The treatment for athlete's foot is a lysol douche.

"The blood groups are 0, 00, and 000."
*Examiner's remark:* Oh! Ooh? and Oooh!

*Student Nurses*

# Preparing to be a Graduate

MARY L. CLIPPERTON

*Average reading time — 3 min. 48 sec.*

NURSING HAS BEEN DEFINED broadly as the promotion of health, the prevention of disease, and the care and rehabilitation of the sick. It is toward the appreciation of such a definition that the nurse's training is directed.

A nurse's preparation to be of some assistance to the community begins as an undergraduate. In her curriculum personal health is emphasized. Health conferences with a member of the teaching staff assist her to plan her activities advantageously. She is encouraged to live a more balanced life by developing interests apart from her professional routine. Through participation in student government and through her contributions to the various phases of residence life she adds to the healthy environment and the spirit of the school community and in turn grows as a school citizen. Thus a personal application of the principles of the promotion of health is made and the young nurse is able to use this application as a foundation for her health teaching.

Her academic course itself emphasizes health throughout. The basic courses of preventive medicine, nutrition, mental hygiene, psychology, and public health are approached through study of the normal human being. Throughout the nurse's entire ward practice emphasis is placed upon prevention in all services; upon mental as well as physical needs in nursing care; and upon teaching health to patients and their families. In each year of training there is also some other community contact with outside health services.

The need for cooperation of the various branches of community nursing becomes apparent, for whether she is working in the hospital or some other community agency, the nurse is working as a member of a team. Only by fulfilling the ideals set out in the definition will she be prepared to meet the community needs. If she understands the purpose of the community service agency, which is the central registry of the various branches of organized help in a community, she has taken the first step. As the hospital is one member of such an agency, the nurse at the bedside is as much a community worker as those in outside health services. Hospital duty gives her a personal contact with individual members of the community and with the various organizations which may collectively assist them, such as the Child Health, Prenatal, and Chest Clinics. She comes to realize the person in the home is that same person who is now her patient. He brings with him his background with all its complex problems and human relationships which bear directly on his recovery. It becomes more and more evident to the student that the psychological disturbances of the patient have far-reaching effects on his recovery and his rehabilitation. It is only by knowing the whole story that helpful and wise treatment can be given. For example, the doctors, nurses, and entire hospital staff can work together on a plan of treatment for an alcoholic but if no one tries to understand the motives and drives

Miss Clipperton received her training with the Metropolitan School of Nursing, Windsor, Ont.

which have been contributing factors to his disease, all their treatment will have been in vain.

When the young nurse graduates there are opportunities unlimited and even her small contribution is important and necessary. It is a wholesome practice for any nurse to share her scientific skills and knowledge with less informed individuals and organizations that move in her orbit. I shall mention a few ways in which she can do this.

If every nurse would encourage only one other young woman to join our profession, there would not be such revealing figures as one nurse for every 553 population in Prince Edward Island, and in Ontario, which is considered most fortunate, one nurse for every 234 persons. There would not be the continued cry for more and more nurses.

A nurse should realize that even after marriage she still has a responsibility to her community and should take an active part in such things as promoting better health standards for young children. For example, she may participate in the Parent-Teachers' Association or help the Blood Banks or teach first-aid classes in a national emergency.

Another contribution which the graduate can make is to continue to place stress on citizenship by taking an active part in community affairs. She should participate energetically in her professional organizations for the purpose of giving something constructive to it rather than only getting something out of it. She should take an interest in politics and legislation. Even if she has no aspirations towards actual membership in parliament, she can at least give her fervent support to those nurses within her professional field who would be capable of holding such positions.

In conclusion, a most significant need is for the nurse to pursue the principles of a broad education by maintaining a keen interest in the humanities. She must avoid the pitfalls of hardening and narrowing. If the nurse does not keep an awareness of changing conditions around her, and learn to appreciate our heterogeneous modern society, her scope is limited. This is not merely a postgraduate project but must begin in her student days. Through a system of controlled students' time this ideal can be realized. In no other way than by continuous interest in professional and civic organizations can a nurse be fully prepared to meet community needs.

# Preparation to Participate

KATHLEEN KING

*Average reading time — 5 min. 12 sec.*

WE SHALL consider our preparation to participate in the activities of our professional organizations. In order to do this, we must agree upon what we mean by a profession. What distinguishes us, as future professional workers from other types of workers? Many definitions have been given but one of the most concise is "the word profession connotes a foundation of science and a motive of service."* As we look at other and older professions we find that the members have come together to form organizations. We, as newer members of the professional group, might ask

Miss King is a student at the University of Toronto School of Nursing.

*Metcalf, H.C. Dynamic Administration; Collected Papers of Mary Follett. Harper & Bros. Publishers, New York, 1940. p. 132.

if such action is really necessary? In answering this question we return to the definition. It calls for a basis of science, or learning, and a desire to serve others. It is not enough to have only the foundation of science. We must always be building on this base as new knowledge is brought to light. A good professional organization will attempt to keep its members informed of such new advances. There is also the other portion of the definition to be considered—"a motive of service." We would all agree that many minds are better than one and that broader objectives may be attained by unity of thought and purpose when many think together.

Our profession is organized on three levels which are interwoven one with the other. By joining our provincial association we automatically become members not only of that group but of the national association—the Canadian Nurses' Association. Through it we are members of the International Council of Nurses as well. By taking part in local meetings of the Registered Nurses' Association we have a voice both in national and international affairs affecting the practice of nursing. The responsibility that this places on each of us needs no further emphasis.

Coming, then, to the preparation which will enable us to take part intelligently and effectively in this organization, we first should know the objectives. These may be summed up under three headings:

1. To elevate the standard of nursing education and practice in order to give the best type of public service.
2. To promote the best interests of the nurses of Canada and to maintain national unity among them.
3. To encourage an attitude of understanding toward the nurses of other countries.

The first step in preparation is the development of excellence in nursing practice and with this development will come knowledge of the weaknesses and strengths in nursing as it is practised. It is only by gaining such knowledge that we may prepare ourselves to present constructive ideas and suggestions regarding the standard of nursing education and nursing practice so that the best possible service may be given.

Nurses individually and through their organizations must study and be ready to accept responsibilities as citizens. This requires preparation with a broad base. To do the task effectively we must try to understand human society so that community needs may be met.

Finally, in our student days, we must acquire sufficient knowledge of our professional organization that will encourage us to participate as graduate nurses. All of us have some hazy ideas about the organization, yet a fuller knowledge of it would be useful to each of us. We should try to understand the work that is being undertaken by the group. This means that we must read, study and think out the problems that are revealed through such official publications as *The Canadian Nurse* and the *R.N.A.O. Bulletin*. We must take part in as many activities as are made available by the district organization. It is by this interest and participation as students that we can hope to develop a better understanding of what professional nursing really means.

We have considered various ways by which we may gain a viewpoint on professional matters which may be of value to the organization. There still remains, however, a very important consideration—that is the development of the ability to express these points of view. Preparation to take part in group activities is essential. Fortunately we are receiving grounding in this method. One particularly valuable form is through group conference. In these conferences each member of a class has the opportunity to prepare a topic and to lead the discussion on a given subject.

Probably we receive most of our preparation to express ourselves in our student associations and in our joint staff and student councils. It is by active participation in such


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organizations that we learn to legislate, administer, and in general to develop a sense of personal concern for matters relating to the entire group. In such councils we must be ready to present suggestions and, if we want them accepted, be prepared to uphold them by reasoned argument. The reverse is also true. We must be prepared to question ideas where we doubt their value.

Along with this experience in presenting and debating questions we learn the procedures by which meetings are conducted. This knowledge is an asset in any group and one which we as trained people should possess. There is a sense of satisfaction that comes from being one of a group working together with a common aim.

We have been talking of professional organizations as apart from one's own school. The importance of each school's alumnae group as a professional association must be remembered. All that has been said regarding the organization and the preparation to take part in professional organizations holds true of our alumnae groups.

In conclusion, I would stress two essentials in our training which should help us to take part in professional organization. They are:

1. To develop initiative and the ability to have and to express a point of view; and (2) to encourage an interest in student nurses which will be maintained after graduation.

Much of this preparation which I have outlined is of an informal nature and is available to all student nurses provided they are convinced of the need for and the value of such a group and are willing to accept their responsibility to participate in professional organization.

## Activities of Student Council at W.G.H.

The Student Council of the Winnipeg General Hospital has enjoyed a very active and interesting year. To start off our activities arrangements were made to purchase a Coca-Cola machine. The price of this machine was $500. We paid $100 down and $20 in monthly payments. To date we have paid $320, leaving $180 due.

Our sports night, held every Tuesday in the Daniel McIntyre Gymnasium, has been a highlight of our activities during the year. The students have enjoyed interclass basketball and volleyball competitions. Square-dancing was also a favorite choice for an evening. Through the able assistance of Mr. Barbour and Miss Wilson of the City Recreational Board, our sports activities were guided for a very successful season.

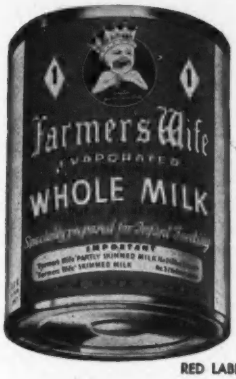
Our student identification cards have been a definite assistance to the student body. Besides providing a means of identification, the privilege of attending a Famous Players Theatre in Winnipeg at the student rate of 35 cents has been obtained. These cards are issued at the beginning of our training, cost us $1.00, and are turned in at the completion of the course with the dollar refund.

There have been a few changes in our class and mass meetings this past year. First our A and B classes divided and each section had a separate class executive, responsible to the Student Council and the students in their section. Secondly, mass meetings which had previously been held three to four times a year were changed to once a month. This change was brought about by the students themselves with voluntary attendance. The mass meetings have been regularly attended with each class section providing a guest speaker and good entertainment. Miss Margaret Nix, of the Public Health Department, spoke to us on Personality Development; Dr. Dwight Parkinson, neurosurgeon on our staff, presented a very interesting film on brain surgery; and Mr. V. Scott, of the Orchid Florists, taught us how to arrange flowers.

The Council itself also made a change in regard to its meetings. They are held regularly at the end of the month to discuss all students' problems. In order to obtain an overall view on student matters, three mass Student Council meetings were held, which all class executives and committees attended, with approximately 50 members present.

The student body appreciated very much the gift of a lovely automatic radio-record

# They all ran after the "Farmer's Wife"

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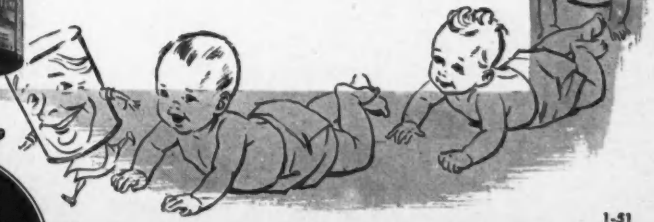


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player and a cheque to purchase records from the president of the Board, as a personal gift.

It has been an active year — a year that has developed in our students a strong school spirit, individual student participation, and personal responsibility to their school and their work. It has been, we hope, an inspiring year to those following our footsteps.

JAMESINE SINCLAIR
*President, Student Council*

## The Widening Scope of Plastic Surgery

PERCY H. JAYES

Until recent years the plastic surgeon was often despised by his professional colleagues who considered that he was solely concerned with cosmetic operations and had no genuine role in the treatment of trauma and disease. Fortunately that erroneous impression has been completely dispelled and plastic surgery has now taken its rightful place as one of the most useful and important specialties. The enormous contribution of plastic surgeons to the treatment of war casualties has been largely responsible for this change of outlook.

In World War I a special plastic unit was established in Britain for the first time and under the leadership of Sir Harold Gillies a team of British and Allied surgeons treated hundreds of cases from the battlefields of Europe. Plastic work continued in the years between the wars but only a few surgeons were able to devote their whole time to this branch of surgery.

World War II, however, necessitated great expansion of the existing services and special plastic units were established in all the big provincial centres to treat civilian air-raid casualties and to receive wounded from the battlefronts. One of the largest of these was the Queen Victoria Hospital at East Grinstead, in southern England, now the finest equipped plastic surgery centre in Europe. Here Sir Archibald McIndoe treated many hundreds of servicemen, including French, American, British, Czech, Polish, Norwegian, Rumanian, Belgian and Dutch.

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Dr. Jayes has been plastic surgeon to Queen Victoria Hospital, East Grinstead, England, since 1940.

In addition to these arrangements, each of the armed forces organized plastic teams which worked in forward areas and at base hospitals. The wounded man was thereby assured of special care right from the earliest moment until the completion of his treatment.

The creation of these wartime units resulted in great progress and development within the specialty of much wider recognition of the possibilities of reparative surgery. By the end of the war a considerable number of fully-trained plastic surgeons was available and, under Britain's National Health Service, permanent units have been established to deal with all the reconstructive problems of peacetime practice.

The advances which have been made in other spheres of medicine have greatly helped the development of plastic surgery. In this connection, anesthesia, blood transfusion and the control of infection by the sulfonamide drugs and penicillin are of special significance. Progress has also been made in the design of instruments and, with machines now available, it is possible to obtain large skin grafts with ease and certainty. Much experimental research work has also been undertaken and this has yielded useful information on a variety of problems, such as the blood supply of pedicle flaps, the refrigeration and preservation of skin grafts, and the

possible use of synthetic plastic materials for the repair of contour defects.

The scope of plastic surgery has increased enormously and it now embraces reconstructive problems in all parts of the body in addition to the repair of the face. The plastic surgeon must work in close cooperation with those engaged in other specialties such as orthopedics, neurosurgery, and opthalmology. For example, in orthopedic work it is essential to have a good skin in the operation area and, when scars and wounds are present, preliminary plastic treatment is often necessary to provide a healthy skin surface.

The modern treatment of burns demands the service of a plastic surgeon. With superficial burns, healing takes place from the deeper layers of the skin which have escaped destruction and grafting is unnecessary but, when the full thickness of the skin has been destroyed, replacement with grafts is essential to obtain rapid healing with preservation of function. The introduction of plasma and blood transfusion has saved many burned patients who would otherwise have perished but these individuals would become hopeless cripples in the absence of skin grafting.

During World War II a large number of extensive burns were encountered, particularly among flying personnel and tank crews, and in some of the worst cases the plastic repair entailed a series of 20 or 30 operations spread over a period of two or three years.

In civilian practice, burns form an important part of the plastic surgeon's work. Accidental burns are quite common, especially in children, and the surgeon is called upon, in the initial stages, to apply grafts to raw surfaces and later to replace scars and relieve contractures.

Gun-shot wounds of the face usually need extensive reconstructions. The nose, lips or cheeks may be repaired with skin conveyed from another part of the body and the tubed-pedicle method, which was elaborated in World War I, is often used for the transference. In peacetime, similar deformities occur as a result of road, air, and industrial accidents, and also following the operative removal of malignant tumors. The methods of repair which were perfected in connection with war casualties are now available for such cases.

The treatment of certain congenital deformities comes into the province of the plastic surgeon. These include harelip, cleft palate, webbed fingers, and birthmarks.

# Book Reviews

**Administration of Schools of Nursing,** by Dorothy Rogers Williams, M.A., R.N. Edited by Isabel M. Stewart, M.A., R.N. 288 pages. Published by The Macmillan Co. of Canada Ltd., 70 Bond St., Toronto 2. 1950. Price $4.00.

*Reviewed by Eleanor S. Graham, Director of Nursing, Royal Columbian Hospital, New Westminster, B.C.*

This text is devoted exclusively to the subject indicated by the title, without any attempt to include the principles of administrative nursing service. In spite of, or perhaps one should say because of, the fact that the majority of schools of nursing are administered in such close relationship with the administration of nursing service, this book should be of great assistance to the many nursing administrators who have the complicated task of reconciling service needs with student needs. Such a book does much to clarify the aims of nursing education and the means of fulfilling these aims.

After outlining the basic concepts of organization in general, the author goes on to trace the development of the different patterns of organization of schools of nursing in the various types of hospital and university schools and the impetus now being given to changes from the traditions inherited from the apprenticeship system and military and medical influences. Then follows a chapter explaining in detail the accepted functions of Boards of Directors and School Advisory Councils.

Separate chapters are devoted to each of several phases of administration: of the *faculty* — with special emphasis on methods of selection; of the *students* — methods of recruitment, selection, orientation, guidance and counselling; of *health and housing;* of the *curriculum;* and *school publicity.* In the chapter on administration of finances, Miss Williams urges a realistic approach in budgeting, estimating the value of student nursing service and setting the amounts of tuition fees and

stipends. In view of the very real problem of securing adequate finances for a student program that is educationally sound, this chapter is particularly helpful in pointing up the means of estimating the true cost of operating a school of nursing.

Administrators, members of nursing school faculties, and post-graduate students in nursing education will find this book of real assistance. The author originally intended to include in her book the administration of nursing service in hospitals conducting nursing schools but she wisely decided to concentrate on administration of schools of nursing because of the trend towards a clearer distinction between the two areas of responsibility.

**Freud: Dictionary of Psychoanalysis.** Edited by Nandor Fodor and Frank Gaynor. 208 pages. Published by The Philosophical Library, Inc. 15 East 40th St., New York City 16. 1950. Price (in U.S.A.) $3.75.

*Reviewed by Anne Kirkham, Assistant Supt. of Nurses, Provincial Mental Hospital, Ponoka, Alta.*

This book is designed to explain the terminology used by Freud in his development of the psychoanalytic theory. It should be kept in mind that this is not meant as a general dictionary but as one dealing with a specific field and point of view. The definitions are direct quotations from Freud's works. As such it presupposes some knowledge and acceptance of his opinions. For the uninitiated some of the definitions will be of little value. For example, in defining the ego, the following statement —"The severest demand upon the ego is probably the keeping down of the instinctual claims of the id, and for this end the ego is obliged to maintain great expenditures of energy upon anticathexis. But the claim made by the super-ego, too, may become so powerful and so remorseless that the ego may be crippled, as it were, for other tasks" — has slight meaning unless the reader knows something of the relationship between the id, ego, and the super-ego.

For those versed in dynamics of human behavior this book will be valuable as a reference text to clarify points without having to search extensively through Freud's writings. A key to the references is given which enables the reader to find the particular section from which it is taken if he desires to read further of the subject. For those less informed the

key will assist in directing their reading into specific channels.

This book would be an asset to the student of psychoanalysis.

**Understanding Natural Childbirth**—A Book for the Expectant Mother, by Herbert Thoms, M.D., in collaboration with Laurance G. Roth, M.D., with picture story by David Linton. 112 pages. Published by McGraw-Hill Co. of Canada Ltd., 50 York St., Toronto 1. 1950. Price $4.50.

*Reviewed by Clara M. Lennie, Royal Alexandra Hospital, Edmonton.*

The co-authors of this book have been successful in presenting briefly, and in the terminology of the laity, the aims and accomplishments of the Natural Childbirth Program, particularly as carried on at the Grace-New Haven Community Hospital (University Service).

It is not a textbook, yet every nurse would do well to read it. What is natural childbirth all about? What can it do for the expectant mother? The hundreds of questions asked of us by friends and acquaintances are simply and ably answered.

The Natural Childbirth Program itself is a system of training the mother-to-be for active participation during labor. This is being proven to be one of the most successful advances in obstetrics today.

Besides presenting a clear, informative picture of this program, the book describes every aspect of pregnancy and labor. This is done extremely well. Along with the picture-story, consisting of nearly 100 actual photographs, it leaves few questions in the mind of the reader.

The brevity of the volume, the generosity of spacing, and the very apt quotations at the beginning of each chapter carry one along to the conclusion. It is a thought-provoking stimulus.

**Encyclopedia of the Eye**—Diagnosis and Treatment, by Conrad Berens, M.D., F.A.C.S., and Edward Siegel, M.A., M.D. 272 pages. Published by J. B. Lippincott Co., Medical Arts Bldg., Montreal 25. 1950. Illustrated. Price $5.75.

*Reviewed by J. Elizabeth Hutcheson, Archer Memorial Hospital, Lamont, Alta.*

The authors of this volume have certainly reached the objective stated in the preface—"a ready reference to the diagnosis and treatment of the more common ophthalmologic

problems." The lack of detail and terms that have been omitted will concern very few of the users.

A section on pediatric ophthalmology is included which is interesting and makes for quick references. The illustrations are excellent, both the colored and the black and white, each group having a normal for comparison. The book is well indexed and with the encyclopedic form, the nurse, unfamiliar with clinical terms, should find her research simplified.

The treatment of diseases and conditions is stated briefly. The drugs used are up to date and it is the intent of the authors to revise the list of drugs periodically as progress in that line is made.

I might complain that nursing care is not included. However, it is not a nursing text and nursing care was not mentioned in the objective so this omission cannot be used as a criticism. The book is not an essential for the general nurse but would be invaluable to a charge nurse or supervisor on an ophthalmologic ward.

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Only 5 per cent of the home accident deaths from falls each year occur among people under 45 years of age; 85 per cent happen in the age group over 65.

Many falls, burns, and other home disasters are attributable to physical infirmities and disabilities. The correction of an eye defect may be all that is needed to make the home safe for grandma or grandpa. A proper diet aimed at overcoming nutritional anemia in an oldster may reawaken reflexes, the failure of which might result in a fall downstairs. Physiotherapy can be employed economically at home, under the guidance of a physician, to improve circulation in aging limbs and bring back some of their waning elasticity. Many other causes of dizzy and fainting spells, petit mal attacks, or paralysis may be minimized by medical treatment. Physical infirmities *per se*, many of them amenable to correction, are important contributing factors in many home accidents.

—*Public Health Nursing*, June, 1951.

## Victorian Order of Nurses

The following are recent staff changes in the Victorian Order of Nurses for Canada:

**Appointments**—Brockville: *Jean Lloyd* (Gen. Hosp., Kingston, and Queen's University) as nurse in charge. Chatham, N.B.: *Dorothy Loane* (Royal Victoria Hosp., Montreal, and Dalhousie University) as nurse in charge. Dartmouth: *Anna Adams* (All Saints' Hosp., Springhill, N.S. and Dalhousie U.). Moncton: *Frances Cook* (Ottawa Civic Hosp. and Dalhousie U.). Niagara Falls: *Ruth Walker* (Victoria Hosp., London, and B.Sc. N., University of Western Ont.). Ottawa: *Olga Winters* (St. Joseph's Hosp., Toronto). Sarnia: *Edna May Stoddart* (Victoria Hosp., London, and B.Sc.N., U.W.O). Saskatoon: *Jean Sawdon* (University of Alta. School of Nursing). Toronto: *Amy Eacott* (Hosp. for Sick Children, Toronto, and U.W.O.).

**Re-appointments**—Toronto: *Cecilia Hamilton, Marion J. Orr.*

**Resignations**—Brockville: *Phyllis Paisley* as nurse in charge. Hamilton: *Alice Julien.* Moncton: *Helen Lafitte.* North York, Ont.: *Frances Krotz.* Sarnia: *Margaret Kenny.* Toronto: *Vera Gray, Eileen Kirton, Catherine Lewis, Mary E. MacLean, Jeanne Sykes.* Winnipeg: *Edith Rose.* Woodstock, Ont.: *Winnifred Briggs.*

# News Notes

## BRITISH COLUMBIA

### VERNON

A practical application of its aims and objectives, which are to foster the nursing profession, is being made by the local chapter. The organization will sponsor a bursary loan of $300 annually to a student from this area entering a school of nursing in a British Columbia hospital. The award will be made after the student is accepted by the hospital and the choice will be largely upon need, an applicant to be selected each December. The bursary takes the form of $200 as a gift — $100 as a loan. Repayment of the $100 must be made within a year following completion of training and is interest-free for six months. The only stipulation attached to the bursary is that the recipient remain in nursing for at least a year.

The details were worked out by a committee, composed of J. Sutcliffe, Mmes R. Clarke, M. Routledge, and H. G. Scarrow, chapter president. A permanent committee to administer the fund will consist of the hospital matron, Mrs. A. Thom, and the aforementioned committee. Funds are raised through bridge parties, rummage sales, and by the operation of a canteen at the hospital.

VICTORIA

*Royal Jubilee Hospital*

Mary McMillan, a 1941 graduate and now on the hospital staff, has received a grant of nearly $1,000 from the Department of National Health and Welfare. Miss McMillan will use the grant to attend the University of British Columbia for a course in nursing administration. She will return to R.J.H. as a clinical supervisor.

## MANITOBA

*Winnipeg General Hospital*

At the annual meeting of the alumnae association, the following officers were elected: Honorary president, E. Gilroy; president, Mrs. C. Dojack; vice-presidents, Mrs. A. J. Wilson, I. Cooper, Mrs. L. Duff; recording and corresponding secretaries, Mrs. G. Kemp, A. Robertson; treasurer, Mrs. M. Sturgeon. Additional executive members include: B. Lee, H. Setka, J. Fremming, J. Jonasson, D. Hibbert, J. Kerr, I. Aikman, Mmes W. H. Anderson, G. McCruden, J. D. McQueen, H. White, E. M. Brock, and R. Emmett.

The annual dinner for the 1951 graduation class, sponsored by the alumnae, was held at the Fort Garry Hotel, with Prof. D. Owens as guest speaker. Dr. Lennox Bell gave the address at the graduation ceremonies when 97 nurses received their diplomas and pins.

## NEW BRUNSWICK

SAINT JOHN

*General Hospital*

Mr. R. H. Gale, superintendent, was chairman at the graduation exercises for the 1951 class of the School of Nursing while Dr. G. M. White, head of the department of gynecology, delivered the address to the graduates. The 42 nurses received their diplomas from Dr. G. B. Peat, chairman of the nursing and treatment services committee of the Board of Commissioners. Jane Stephenson, director of nursing, presented the class pins. The invocatory prayer was offered by Rev. J. M. Humphreys. Prize winners included the following: V. Friars, D. Mosher, M. Cowan, D. Ross, E. Vincent (valedictorian), M. Coleman.

Following the exercises a reception for the graduates was held at the Admiral Beatty Hotel by the Board of Commissioners. The guests were received by Dr. Peat, Mr. Gale, Mrs. E. R. Hagerman, lady commissioner, and Miss Stephenson.

*St. Joseph's Hospital*

Twenty graduates received their diplomas at the graduation exercises of the School of Nursing. In the morning, His Excellency Most Rev. P. A. Bray, C.J.M., Bishop of Saint John, celebrated a special Mass in the hospital chapel. Prior to commencement, Rev. Dr. J. M. Gallagher, chancellor of the diocese and hospital chaplain, officiated at the Benediction of the Blessed Sacrament. Dr. L. R. Morse, president of the hospital standardization board, presided at the exercises. Bishop Bray presented the diplomas and Rev. Dr. Gallagher the awards. The guest speaker

was Dr. J. A. MacDougall. Greetings from the Board of Directors were extended by Mr. Harold E. Kane, vice-chairman. Guest soloists included S. McIntyre and D. McNulty. A reception followed the ceremonies.

### NOVA SCOTIA

LIVERPOOL

The Queens-Shelburne Branch met at Broad River Cottage for the June meeting with Jean Nickerson as hostess. Dr. J. C. Wickwire gave a talk entitled "Physical Signs and Symptoms of Cardiac Disease — Cause and Treatment."

### ONTARIO

DISTRICTS 2 AND 3

SIMCOE

The Business and Professional Women's Club has arranged to provide $100 annually to a student desiring to enter a school of nursing and needing financial assistance. Fifty dollars will be given at the time of entering the school and the remainder at the end of the probationary period.

The Community Nursing Registry has taken the initial steps towards the expansion of its program to conform with the provincial plan.

The nurses of Norfolk General Hospital held a successful garden tea and sale of fancy work, candy, and home-cooking. The proceeds will be applied toward hospital equipment.

DISTRICT 5

*Toronto General Hospital*

The Roof Garden of the Royal York Hotel was the scene of the banquet tendered by the alumnae association in honor of the 1951 class, numbering 95. N. Rae, president, Student Government Association, was toast mistress. Mary Macfarland, superintendent of nurses, D. McMillan, P. Lonstaffe, and Miss Ives participated in the various toasts. J. Gauley introduced Ruth Parkhouse, valedictorian, who was thanked by M. A. Tolmie.

The alumnae Mother and Daughter Tea was also held to honor the 1951 class. Receiving the guests were Mrs. H. E. Martin, president; Miss Macfarland, I. Ferguson, social convener, and Miss Rae. Doing honors at the tea table were: L. Bailey, L. Shearer, S. Williams, M. McDonald, B. Beyer, M. Dix, M. Burell, Mmes F. Doyle, M. W. McCutcheon, R. Gordon, E. Morgan. Each graduate received a single rose corsage, gift of the alumnae. Over 400 guests and members were present.

A bridge, sponsored by the alumnae Membership Committee, of which J. Dodds is convener, was held to stimulate interest and gain support for the alumnae. Attendance passed the 160 mark. A special attraction of the program was a "Spring Fashion Preview" by Mrs. Coulter of Robert Simpson Co. This included a showing of the latest styles through the media of colored pictures.

Cora Kilborn, who spent many years in China, is now at Rosedale War Memorial Hospital, Matheson. Marion (Mack) Webber is

doing general duty at Springfield, Mass., where her husband is resident in surgery. K. Connor, who is superintendent of nurses at the sanatorium in Calgary, has been granted leave of absence to do survey work for the Canadian Tuberculosis Association. With another graduate from eastern Canada she has been the guest of the Prevention of Tuberculosis Association of England. E. Stella Hall, medical records librarian, retired in April after 25 years' service.

### District 8

*Ottawa Civic Hospital*

The following officers are serving for the alumnae association for the 1951-52 season; Honorary presidents, G. M. Bennett, E. Young; president, E. Horsey; vice-presidents, V. Adair, Mrs. J. Edgar; recording and corresponding secretaries, D. Clark, L. Barry; treasurer and assistant, M. Lamb, W. Gemmell. Additional executive members include: J. Eckford, E. Poitras, D. Johnstone, J. Milligan, B. Graydon, H. Campbell, Mmes H. M. Weld, D. L. Lindsay, D. K. Dale, G. Currie, C. Cheesman.

Lois (Adair) Dolan is working in the office of an industrial surgeon in Chicago. Sally Ann (Broadbent) Avery is nursing at the Ste. Anne de Bellevue D.V.A. Hospital. R. Williamson is on the staff of Peterborough Civic Hospital. Jean Muir is at Moncton Hospital. P. Baird is attached to the Grenfell Mission in St. Anthony, Nfld. Mary Shaw, after completing a post-graduate course at Margaret Hague Maternity Hospital, Jersey City, joined the R.C.A.M.C. J. Wickware is supervisor of nurseries at Sloan Hospital, New York. Shirley (Mutter) Brett is at the Workmen's Compensation Hospital, Malton, Ont. E. Munroe is doing public health with the Bruce County health unit at Lucknow, Ont. M. Cooke, for several years a missionary nurse in Egypt and China, is now with the O.C.H. admitting department. M. Stitt is chief instructor at McKellar Hospital, Fort William. R. Swartz is in charge of the Protestant Children's Village, Ottawa. M. Carrs is at the Port Arthur General Hospital. E. Arnold resigned from the Civic to join the R.C.A.M.C. M. Archibald, formerly with O.C.H., is industrial nurse with The Bell Telephone Co., Ottawa. L. Moke is on the staff of the Hospital for Sick Children, Toronto.

P. Borthwick completed the course in psychiatric nursing at the Allan Memorial Institute, Montreal, while D. Maves took obstetrics at Margaret Hague. H. Wilson studied teaching and supervision in public health nursing at University of Toronto. D. Ainger and E. Read attended McGill University.

### District 10

The district recently entertained at a dance in honor of the graduating classes of the three Lakehead schools of nursing — McKellar, St. Joseph's, and Port Arthur General hospitals. Receiving the guests were Mrs. D. R. Easton, district president, D. Colquhoun, director of nurses at Port Arthur General Hospital, and D. Shaw, assistant director of nurses at McKellar Hospital, Fort William. Dr. B. C. Hardiman was master of ceremonies. The dance was convened by H. Scrimgeour, assisted by H. Keith and P. Postans.

## QUEBEC

### Quebec City

*Jeffery Hale's Hospital*

At a recent meeting of the alumnae association reports were received from nurses who attended the annual meeting of the A.N.P.Q. in Montreal. Those present at the convention

included: Misses B. A. Beattie, MacDonald, Radley-Walters, Walsh, and Jack, and Mmes Green and Pugh.

The Chateau Frontenac was the scene of the annual dinner given in honor of the 1951 graduates when the class prophecy was read by S. Fox. An interesting talk was given by Mrs. Kemp. The following evening the graduation exercises were held when 15 nurses received their diplomas. Prize winners included: Misses Goodday, Smith, Currie, Crowe, and Des Ruisseaux. The address to the graduates was given by Dr. W. L. Delaney and vocal selections were rendered by a choral group of teen-age boys. A formal dance was another enjoyable event in honor of the new class.

Showers were held for Misses Costello and Miller in honor of their marriages. Miss Felsing, instructor, was also entertained on her departure to attend McGill University. Miss Ward has resigned as ward supervisor to be married. Misses MacNeil and Brown are on the staff of the hospital in Arvida.

### SASKATCHEWAN

YORKTON

*General Hospital*

Fifteen members attended the annual meeting of the alumnae association when reports from the various officers and committees revealed an active year. It was learned from Mrs. Ellis that $34.31 had been realized from a rummage sale. Mrs. Westbury told the members that ticket sales on a draw for a portable radio netted $125.37. It was agreed to purchase colored film to be used in taking outdoor pictures of the graduating class. Mmes Parker and Darroch were appointed to the auditing committee. Letters of thanks were read regarding assistance rendered by the members during a survey of the city for tuberculosis and the annual Cancer Drive.

The following officers will serve during the coming months: Honorary president, Mrs. L. V. Barnes; president, Mrs. J. Parker; vice-president, J. Tate; secretary, Mrs. M. Campbell; treasurer, Mrs. E. Parrott. Councillors, Mmes F. Wiley, S. T. Dodds; social convener, Mrs. Sam Dodds; *Canadian Nurse* representative, Mrs. T. E. Darroch.

Twenty graduates received their diplomas and pins at the 46th graduation exercises of the School of Nursing. Mr. S. N. Wynn, chairman of the Board of Governors, presided. Rev. J. E. Jones gave the invocation. The address to the graduates was given by Dr. F. B. Roth, director, Hospital Administration and Standards, Saskatchewan Department of Public Health. Awards, presented by Dr. M. Yaholnitsky, were received by: D. Kendel, I. Porter, (valedictorian), D. Ward, M. Einarson, R. Pomeroy. Vocal numbers were rendered by a trio — B. Hart, N. McKenzie, and I. Young — and the student nurses.

Following the exercises, a reception and dance were held when K. Francis, superintendent of nurses, and B. Hart, instructor, received with the graduates. Presiding at the tea table were: Misses Francis and Lys, Mmes F. Steele, S. N. Wynn, D. McMillan, H. Portnuff, M. Yaholnitsky, C. J. Houston.

# Positions Vacant

*Advertising Rates—$5.00 for 3 lines or less; $1.00 for each additional line.*

**Director of Nurses** for new General Hospital with General Duty Nursing Staff. Apply District Memorial Hospital, Tillsonburg, Ont.

**Nursing Arts Instructor & General Duty Nurses** for 200-bed hospital. Salaries: $195-175 plus Cost of Living Bonuses, respectively. 8-hr. day, 88-hr. fortnight. Statutory holidays. Sick time. 4 wks. annual vacation. Apply Supt. of Nurses, Royal Inland Hospital, Kamloops, B.C.

**Supervisor for Pediatric Dept.** Salary: $160 plus maintenance. 28 days vacation. **Registered Nurses for General Duty** in 200-bed hospital. Salary: Days, $140; evenings, $150; nights, $145—plus maintenance. 21 days vacation. Increments & cumulative sick leave. **Certified Nursing Assistants.** Salary: $100 plus maintenance. 21 days vacation. For further information apply Director of Nursing, County General Hospital, Welland, Ont.

**Registered Nurses for General Duty** for 20-bed Isolation Hospital. Salary: $200 per mo. Meals & laundry. 8-hr. broken duty. 5½-day wk. Apply Arthur H. Evans, Sec., Board of Health, Port Arthur, Ont.

**General Duty Nurses** (2) for 20-bed General Hospital. Beginning salary: $210 per mo. 48-hr. wk., rotating shifts. 2 wks. paid vacation after 1 yr. & 1 wk. sick leave & time out for holidays. Williams is town of 3,000 located in Northern Arizona at an elevation of 6,500 ft. Good climate. Air mail replies, giving training & experience, to Williams Hospital, Williams, Arizona.

**Clinical Instructor in Surgical & Obstetrical Nursing.** Salary range: $250-270 with merit increases to $290. Also **Asst. Instructor in Nursing Arts.** Salary range: $245-255. **General Staff Nurses** for vacation relief or permanent duty on Medical, Surgical, Obstetrical & Communicable Disease floors & Newborn Nursery. Salary range: $220-240 with differential of $15 per mo. for evening & night duty. 3 wks. vacation. 6 legal holidays or equivalent. For General Hospital on Lake Michigan, 14 miles from Chicago. Apply Director of Nursing, Evanston Hospital, Evanston, Illinois.

**General Duty Nurses & Dietitian** for 85-bed hospital. Good salary. 44-hr. wk. Statutory holidays. 28 days vacation. 1½ days per mo. sick leave. Apply Sister Superior, St. Eugene Hospital, Cranbrook, B.C.

**Graduate Nurses** (2) for 14-bed hospital. Rotating shifts. 8-hr. day, 6-day wk. 1 mo. vacation at end of yr. Apply Supt., Grand Manan Hospital, Grand Manan, N.B.

**Registered Nurses** for 250-bed approved hospital. 40-hr. wk. $215 base pay. Additional $20 for evening duty & $10 for nights. $5.00 increase every 6 mos. until $50. Mo. paid vacation per yr. Apply Director of Nursing Service, St. Elizabeth Hospital, Yakima, Washington.

**Registered Nurse** immediately for 3-year-old hospital. 21 adult beds plus 7 bassinets & children's beds. Salary: $150 per mo. plus full maintenance. 8-hr. day, 6-day wk. 1 mo. holiday with salary per annum. Private rooms in nurses' residence. Good train connection daily except Sun. to Regina & Saskatoon. Wire or phone collect Matron, Union Hospital, Leroy, Sask.

**Dietitian** (experienced). Write, giving full particulars & when available, to Matron, King Edward VII Memorial Hospital, Bermuda.

**General Duty Nurses.** Positions available in Alameda, Berkeley, Oakland, Richmond & other California East Bay cities. Nurses registered in their home states or Canada can secure temporary permits to practise nursing in California until Jan. 1, 1954, without examination. Permits may be secured by applying to the Calif. State Board of Nurse Examiners, Sacramento Calif. The following salaries & personnel practices have been established for nurses in the above area: Starting salary: $240 per mo.; $2.50 per mo. tenure increases for each 6 mos. of service to a maximum of 3 yrs. A premium of $10 per mo. paid for night & evening duty; $10 premium also paid for delivery room or operating room duty. 40-hr. wk. 2 wks. vacation for each yr. service. 3 wks. vacation for 5 yrs. service. 7 paid holidays. Sick leave cumulative to 20 work days. Blue Cross Hospital Insurance paid by hospital. For further information write directly to the Director of Nurses of one of the following hospitals: Alameda Hosp., Alameda; Albany Hosp., Albany; Alta Bates Hosp., Berkeley; Children's Hosp. of the East Bay, Oakland; Concord Hosp., Concord; East Oakland Hosp., Oakland; Herrick Memorial Hosp., Berkeley; Martinez Community Hosp., Martinez; Merritt Hosp., Oakland; Peralta Hosp., Oakland; Permanente Hosp., Oakland; Pittsburg Community Hosp., Pittsburg; Providence Hosp., Oakland; Richmond Hosp., Richmond.

**Industrial Nurse** for large manufacturing plant near Medicine Hat. Must be qualified. Salary: $220 per mo. Pension & insurance plans available. Regular hours. Apply Dominion Glass Co. Ltd., Redcliff, Alta.

**Nurse-Administrator** for 30-bed hospital near Toronto, to be opened Jan. 1952. Apply, stating experience, references, salary required & date available, to Ajax & Pickering Township General Hospital, Ajax, Ont.

**Science Instructor** for 125-bed General Hospital. 40 student nurses. 8-hr. day. 4 wks. vacation. Excellent salary. Apply, stating qualifications, Supt., Soldiers' Memorial Hospital, Orillia, Ont.

**O.R. Supervisor with P.G., Scrub Nurse, Night Supervisor & General Duty Nurses** for modern 100-bed hospital. Basic salaries respectively: $205, $185, $195, $175 plus present C.O.L. adjustments, $20. 44-hr. wk. 4 wks. annual vacation. Sick time. 10 statutory holidays. Apply Supt. of Nurses, General Hospital, Chilliwack, B.C.

**Operating Room Supervisor.** Salary: $210 per mo. gross. **General Duty Nurses.** Salary: $165-175 per mo. gross, depending on experience. 44-hr. wk. 2½ days holiday per mo. Half days on statutory holidays. 1½ days per mo. sick time cumulative to 30 days. Charge of $30 per mo. made for board & room. Apply Supt. of Nurses, General Hospital, Medicine Hat, Alta.

**Supervisor & General Duty Nurses** for 60-bed General Hospital. Excellent salaries. 44-hr. wk. Apply Supt., Public Hospital, Smiths Falls, Ont.

**Public Health Nurse** (qualified). Salary according to experience. Car provided or car allowance. Desirable position close to Toronto. Apply Medical Officer of Health, York County Health Unit, Newmarket, Ont.

**Public Health Nurses** (2) for expansion of Timiskaming Health Unit. Generalized program in towns & rural area. Salary: $2,300-2,700 adjusted according to experience with annual increment. Provision for use of Unit owned car or car may be purchased through Unit free of interest. Blue Cross, medical care, holiday & sick leave benefits. Write Director, Timiskaming Health Unit, Kirkland Lake, Ont.

**Graduate Nurses** (2) for 56-bed hospital in North-Central B.C. Basic salary for B.C. registrants: $185 gross; $44.25 deductions for full maintenance in newly constructed residence. Ample recreational facilities. Apply, giving particulars of training & experience, Miss M. Rowe, Supt. of Nurses, Wrinch Memorial Hospital, Hazelton, B.C.

## CANADIAN RED CROSS SOCIETY

invites applications for **Administrative** and **Staff** positions in **Hospital, Public Health Nursing Services,** and **Blood Transfusion Service** for various parts of Canada.

- The majority of opportunities are in **Outpost Services** in British Columbia, Saskatchewan, Manitoba, Ontario, Quebec, New Brunswick, and Nova Scotia.
- Commensurate salaries for experience and qualifications. Transportation arrangements under certain circumstances.

*For further particulars apply:*

**National Director, Nursing Services, Canadian Red Cross Society, 95 Wellesley St., Toronto 5, Ontario.**

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**Graduate Nurses for General Duty** on medical, surgical & obstetrical floors. 83-bed hospital located near Chicago. Apply Personnel Director, Highland Park Hospital, Highland Park, Illinois.

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**General Duty Nurses** for 40-bed hospital. 44-hr. wk. 28 days annual vacation plus 10 statutory holidays. Annual increases & sick leave. Self-contained nurses home. Commencing salary: $185 plus $10 monthly bonus. Full maintenance, $40 per mo. Apply Administrator, General Hospital, Princeton, B.C.

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**General Duty Nurses.** Salary: $155 less $25 for full maintenance. Increases of $5.00 after 6 mos. & at end of 1st yr. 8-hr. duty. Fare beyond 200 miles refunded. 2 wks. sick leave & 1 mo. holiday with pay—all after 1 yr. service. **Evening Supervisors.** Salary: $185 less $25 full maintenance. Fare, sick leave & holiday as above. Apply Supt., General Hospital, Kenora, Ont.

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**Registered Nurses for General Duty** in 33-bed hospital. Salary: $160 per mo. plus $38 living-out allowance. $5.00 increase after every 6 mos. service. 8-hr. shift. 3 wks. holiday with pay plus statutory holidays. Apply Supt., Memorial Hospital, St. Marys, Ont.

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**General Duty Nurses** (2) for 60-bed hospital. 48-hr. wk. Salary: $140 per mo. with 3 annual increments of $5.00. Full maintenance. 4 wks. vacation at end of 1 yr. service. Apply Supt., General Hospital, Goderich, Ont.

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**Graduate Nurses** for completely modern West Coast hospital. Salary: $190 per mo. less $40 for board, residence, laundry. $10 annual increments. Special bonus of $10 per mo. for night duty. 1 mo. vacation with full salary after 1 yr. service. 1½ days sick leave per mo. cumulative to 36 days. **Working Supervisor for Obstetrical Ward.** Salary to commence at $215 per mo. Transportation allowance not exceeding $60 refunded after 1st yr. Apply, stating experience, Miss E. L. Clement, Supt. of Nurses, General Hospital, Prince Rupert, B.C.

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**General Duty Nurses** for 680-bed General Hospital with School of Nursing. Beginning salary: $255 with $10 additional for special services, p.m. & night shifts. $13 increase after 6 mos. $14 additional increase 1 yr. after 1st increase. 40-hr. wk. 11 paid holidays. 3 wks. vacation. Free laundry. Cumulative sick leave. Full maintenance if desired at $45 per mo. Apply Director of Nursing Service, General Hospital, Fresno, California.

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**Operating Room Nurse** for small hospital. Good salary. Excellent living conditions & recreational facilities. Apply R. R. Buchanan, Director, Industrial Relations, Consolidated Paper Corp. Ltd., P.O. Box 69, Montreal, Que.

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**Director of Nursing** for 90-bed General Hospital situated in progressive Central B.C. city, served by air, rail & bus. Apply Administrator, Prince George & District Hospital, Prince George, B.C.

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**Science Instructor** for School of Nursing in 75-bed General Hospital. Prepared to pay liberal salary & one-way rail fare refunded after 1 yr. service. Apply, stating qualifications, previous experience, etc., Supt. of Nurses, General Hospital, Portage la Prairie, Man.

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**Matron.** Salary: $195 per mo. less $20 for maintenance. **General Duty Nurses** (2). Salary: $165 per mo. less $20 for maintenance. 17-bed hospital. Pleasant working conditions. Convenient to Calgary & Edmonton. Hospital Board will pay railway fare if period of employment is 6 mos. or over. 1 mo. leave with pay after 1 yr. service. Statutory holidays. 48-hr. wk. with no split shifts. Apply A. J. Schmiedl, Sec.-Treas., Municipal Hospital, Elnora, Alta.

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**Science Instructor** for small School of Nursing starting Sept. 1. Good salary. 40-hr. wk. & 4 wks. vacation per yr. Apply Director of Nurses, Jeffery Hale's Hospital, Quebec City, Que.

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**PROVINCIAL MENTAL HEALTH SERVICES OF BRITISH COLUMBIA**

**SCHOOL OF PSYCHIATRIC NURSING**

Announces a six-month course in ***Psychiatric Nursing*** for *Graduate Registered Nurses.*

The course includes lectures in Psychiatry, Psychiatric Nursing, Clinical Ward Experience, Demonstrations in Field Trips. It provides specialization to prepare Graduate Nurses for Head Nurse positions.

During the entire period the student will receive a monthly stipend of $75 per month. Residence & meals will be supplied at a very reasonable cost or the student may live out if desired. Laundry is provided free of charge. The hospital offers recreational facilities & is within easy travelling distance to Vancouver & New Westminster.

*For information apply to:*

**Director of Nursing, Provincial Mental Hospital, Essondale, B.C.**

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**Asst. Director of Nursing.** Full maintenance. Ideal living conditions. Apply Miss C. MacCullie, Director of Nursing, General Hospital, Woodstock, Ont.

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**Nursing Arts Instructor** for General Hospital, Hamilton, Ont. Nurse experienced in bedside nursing & ward administration & with post-graduate course in Teaching & Supervision required. Initial gross salary bi-weekly: $99 plus Cost of Living Bonus of approx. $3.00. 44-hr. wk. For other perquisites—vacation, illness, pension, etc.—& further information apply Supt. of Nurses.

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**Graduate Floor Duty Nurses** for Mt. Hamilton Maternity Hospital, Hamilton, Ont. 44-hr. wk. Statutory holidays. Initial gross salary bi-weekly: $79 plus Cost of Living Bonus. For other perquisites & further information write Supt.

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**Graduate Floor Duty Nurses** for General Hospital, Hamilton, Ont. Gross initial bi-weekly salary: $79 plus Cost of Living Bonus of approx. $3.00. 44-hr. wk. For other perquisites & further information write C. E. Brewster, Supt. of Nurses.

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**Public Health Nurses** for Northumberland-Durham Health Unit following the marriage of 6 staff nurses during past yr. Generalized program in towns & rural areas provides experience in all phases of public health. Salary schedule: $2,200-2,900. Car provided or car allowance. Inquiries to Dr. C. W. MacCharles, Director, Northumberland-Durham Health Unit, Cobourg, Ont.

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**Science Instructor & Clinical Supervisor.** Full maintenance. Ideal living conditions. Apply Miss C. MacCullie, Director of Nursing, General Hospital, Woodstock, Ont.

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**Asst. Supt. of Nurses & Nursing Arts Instructor** for Provincial Mental Hospital, Ponoka, Alta. 1,450-bed, active treatment hospital, conducting an accredited School. Apply, stating qualifications, experience & year of graduation, to Supt. of Nurses.

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**Registered Nurses for Operating Room & General Staff Duty** for University of Alberta Hospital, Edmonton. (640 beds to be increased to 950 with opening of new wing in Sept.) Gross salary: $195 per mo.—1st yr.; $205—2nd yr.; $215—3rd yr. of service in hospital. $25 per mo. deducted for meals & laundry. 11 statutory holidays annually. Sick leave, 3 wks. after 1 yr. service with annual increase of 1 wk. to maximum of 13 wks. Blue Cross coverage on 50% employee contributory basis. Pension Plan. 1st class railway fare to Edmonton refunded after 1 yr. continuous service. Pleasant university environment. Apply Supt. of Nursing Services.

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**General Duty Nurse** for Municipal Hospital, Brooks, Alta. Situated on C.P.R. main line between Winnipeg & Vancouver. Salary: $145 & full maintenance with $5.00 increment every 6 mos. Sick leave with pay. Holidays with pay & statutory holidays each yr. 8-hr. day, 6-day wk. District noted for hunting, fishing & holiday resorts located on Trans-Canada highway. Apply Miss M. Ellis, Supt.

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**Science Instructor** for School of Nursing with 90-100 students. 36 students enrolled for Sept. class. 1 class per yr. Post-graduate training essential. Good classroom facilities. Apply, stating qualifications, Director of Nursing, Civic Hospital, Peterborough, Ont.

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**General Duty Nurses** for modern, well-equipped hospital in picturesque Lakehead. 45-hr. wk. Cumulative sick leave. 1 mo. vacation after 1 yr. service. Gross salary per mo.: $185 less $20 for meals. A further $25 charged if living in residence. Annual increment. Railway fare up to $50 with 1 yr. contract. **Pediatric Supervisor** (teaching & administrative). $225. **Asst. Night Supervisor.** Rotating 3-11, 11-7. $225-235 depending on qualifications. Apply Director of Nursing, General Hospital, Port Arthur, Ont.

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**THE PROVINCE OF MANITOBA** ***requires. . .***

**A SENIOR INSTRUCTRESS OF NURSING**

A Registered Nurse, preferably with Mental Nursing Certificate, for the above position at the **Hospital for Mental Diseases, Selkirk, Manitoba.** Applicants must be capable of supervising educational program for undergraduate and graduate nurses, under direction of Superintendent of Nurses.

The above position offers regular annual increases, liberal sick leave with pay, 4 weeks' vacation with pay annually, and pension privileges.

Apply, stating age, qualifications, and salary expected, to:

**The Superintendent of the hospital in question**

*or the*

**Manitoba Civil Service Commission, 247 Legislative Bldg., Winnipeg, Man.**

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**Vancouver General Hospital** requires: **General Staff Nurses**—Salary: $185-215 plus afternoon & night shift differential. Perquisites: 44-hr. wk.; 11 statutory holidays; 28 days vacation; 1½ days per mo. cumulative sick leave; Pension Plan (if under 35). Apply Director of Nursing, General Hospital, Vancouver, B.C.

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**Registered Nurses, General Staff, for new hospital opened July.** Starting gross salary: $175 per mo. 46-hr. wk. 2 increases in salary. $10 differential for afternoon duty. 28 days vacation after 1 yr. For further details apply Director of Nurses, General Hospital, Guelph, Ont.

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**Operating Room Supervisor** for General Hospital, averaging 30-35 operations daily. Also **General Staff Nurses** with Operating Room experience. Apply, stating age, qualifications & experience, c/o Box C, The Canadian Nurse, Ste. 522, 1538 Sherbrooke St. W., Montreal 25, Que.

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**Registered, Graduate & Undergraduate Nurses** for small hospital in attractive northern Ontario town. Salary: $140 per mo. plus full maintenance to R.N.'s. Others according to qualifications. Apply Supt., Lady Minto Hospital, Cochrane, Ont.

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**British Columbia Civil Service** requires: ***Registered Nurses for General Staff Duty for the Division of Tuberculosis Control***—*Vancouver Unit:* 225-bed T.B. Hospital, located at 2647 Willow St., Vancouver. All major services & student affiliation course. Registration in B.C. required. Gross salary: $182 per mo. Annual increments of $60 (over 5-yr. period). No residence accommodation. *Tranquille Unit:* 350-bed T.B. Hospital, located 12 miles from Kamloops in southern interior. All major services except student affiliation. Gross salary: $188.50 per mo. Annual increments of $60 (over 5-yr. period). New modern residence; attractive bed-sitting rooms. Recreational facilities. Main tenance deduction: Room $5.00; laundry $2.50. Excellent food at 20 cts. per meal. ***Conditions—Both Units:*** 8-hr. day, 5½-day wk. rotating shifts. 4 wks. annual vacation with pay plus 11 statutory holidays. Sick leave, 20 days per yr. (14 cumulative). Promotional opportunities. Superannuation. Write for information & applications to Supt. of Nurses in respective Units or to Director of Nursing, Division of T.B. Control, 2647 Willow St., Vancouver, B.C.

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**General Duty Nurses** for Operating Room, Pediatrics, General, Surgical & Medical Nursing for summer relief or permanent positions. For information & personnel policies apply Director of Nursing, Victoria Hospital, London, Ont.

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**Registered Nurses for General Staff Duty** on Rotation Service. Apply Director, Shriners' Hospital for Crippled Children, 1529 Cedar Ave., Montreal 25, Que.

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**General Staff Nurses** for active 35-bed General Hospital, 50 miles from Toronto. Apply Supt., Lord Dufferin Hospital, Orangeville, Ont.

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**General Staff Nurses.** 44-hr. wk, 8-hr. day. Gross monthly salary: $193.50 ($210.50 less perquisites—2 meals & laundry, $22.50). Apply Director of Nursing, Civic Hospital, Ottawa, Ont.

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**Public Health Nurses** for Provincial Health Unit with rural generalized program. Car provided or car allowance. Apply in writing, stating qualifications, experience, age, etc., Miss Mona Wilson, Director, Public Health Nursing Division, 188 Prince St., Charlottetown, P.E.I.

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**Registered Nurses for General Staff** at Ontario Hospitals in Brockville, Hamilton, London, New Toronto, Orillia, St. Thomas, Toronto, Whitby, Woodstock. Initial salary: $1,840 per annum plus $240 Cost of Living Bonus, less perquisites ($26.50 for room, board, laundry). Annual increment, accumulative sick leave, superannuation, 3 wks. vacation, statutory holidays & special holidays with pay. 8-hr. day, 44-hr. wk. Apply Supt. of Nurses at above hospitals.

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**Graduate Nurses for General Duty.** Gross salary: $180 with additional $5.00 when registered in British Columbia. Annual increments. Statutory holidays. Good living accommodation & cafeteria service at reasonable cost. Apply Supt. of Nurses, West Coast Hospital, Port Alberni, V.I., B.C.

**Instructor of Nursing & Clinical Supervisor.** Apply Director of Nursing, Victoria Public Hospital, Fredericton, N.B.

**General Duty Nurses.** Salary: $163.40 per 4 wks. 26 pays in a yr. on a bi-weekly basis. Salaries have scheduled rate of increase. 48-hr. wk. 8-hr. broken day: 3-11, 11-7, rotation. Cumulative sick leave. Pension Plan in force. Blue Cross. 3 wks. vacation after 1 yr. service. Apply Supt. of Nurses, Muskoka Hospital, Gravenhurst, Ont.

**Nursing Arts Instructor** for teaching staff of 450-bed hospital. 165 students. Apply, stating qualifications, Director of Nursing, General Hospital, Saint John, N.B.

**General Duty Nurses** for 430-bed hospital. 44-hr. wk. 11 statutory holidays. Salary: $175-213 plus $20 C.O.L. Credit for past experience. Annual increments. Cumulative sick leave. 28 days annual vacation. Apply Director of Nursing, Royal Columbian Hospital, New Westminster, B.C.

**General Duty Nurses** for 350-bed Tuberculosis Hospital in centre of Laurentian summer & winter resort area, 2 hrs. from Montreal. Starting salary: $125 per mo. plus full maintenance. Attractive working hrs. with 1½ days off weekly & 1 week-end each mo. 1 mo. annual vacation. 14 days sick leave. Apply Director of Nursing, Royal Edward Laurentian Hospital, Ste. Agathe des Monts, Que.

**Asst. Supervisor for Operating Room** of 450-bed General Hospital. Apply, stating qualifications & salary expected, Director of Nursing, General Hospital, Saint John, N.B.

**Dietitian** for 100-bed hospital. Salary depends on experience & qualifications. For particulars apply Supt., Soldiers' Memorial Hospital, Campbellton, N.B.

**Registered Nurses for General Duty Staff.** Salary commences at £37-10-0 per mo. with full maintenance. Transportation allowance. For full particulars apply Matron, King Edward VII Memorial Hospital, Bermuda.

**Public Health Nurses** immediately for Greater Montreal Branch, Victorian Order of Nurses. Interesting program of nursing care & health counselling in homes. Stimulating staff education program. 5-day wk. 4 wks. vacation. Initial salary: $2,160. Apply District Supt., V.O.N. 1246 Bishop St., Montreal 25, Que.

**Matron** immediately for new 4-bed hospital at Roland, Manitoba. Salary: $165 per mo. **Registered Nurse.** Salary: $150. **Registered Practical Nurse.** Salary: $100. Apply George Muir, Roland, Man.

**General Duty Nurses** for new 30-bed hospital. Salary: $140 per mo. plus full maintenance. 8-hr. duty, 6-day wk. 4 wks. vacation with pay. **Registered Nurse for Central Supply & Operating Room.** Apply Supt., Niagara Cottage Hospital, Niagara-on-the-Lake, Ont.

**Dietitian** for 400-bed hospital. Must be graduate of recognized School of Dietetics. Apply Miss Elizabeth S. Bayley, Chief Dietitian, General Hospital, Saint John, N.B.

**Registered Nurses for General Duty** for 50-bed hospital in town on Lake Ontario, near Toronto. Salary: $170 per mo. with additional $10 for 4-12 duty. Apply Supt. of Nurses, General Hospital, Cobourg, Ont.

**Registered Nurses** (2) for 21-bed hospital. Salary: $165 per mo. plus full maintenance. Regular 8-hr. shifts. 6-day wk. 1 mo. vacation after 1 yr. service. Separate nurses' residence. New wing to be completed this Fall. Apply Matron, Union Hospital, Cabri, Sask.

**Operating Room Nurses** (experienced). Beginning salary dependent on previous experience. Substantial semi-annual increase 1st yr. & annually thereafter for 3 yrs. Basic beginning salary for inexperienced **Registered Nurse,** $147.50 plus 2 meals & laundry. 48-hr. wk. Straight shift. Evening & night shift differential. Sick leave. Statutory holidays. 14 days vacation 1st yr. & 1 mo. thereafter. **Science Instructor** for 1952-53 (experienced with B.Sc. required). Beginning salary dependent on experience & qualifications. Monetary recognition for B.Sc.

**General Duty Nurses.** Basic beginning salary, $147.50 plus 2 meals & laundry. Apply Supt. of Nurses, General Hospital, Winnipeg, Man.

**General Duty Nurses** (2) for Skidegate Inlet General Hospital, Queen Charlotte Islands, B.C. Salary: $170 per mo. less $15 for board & residence. $10 annual increments. 1 mo. salary after 1 yr. service. Transportation allowance one way after 6 mos. service. Return after 1 yr. Apply Sec.

# Official Directory

## Provincial Associations of Registered Nurses

### ALBERTA

**Alberta Association of Registered Nurses**

Pres., Miss F. Ferguson, 5 Glenwood Manor, Calgary; Past Pres., Miss J. Clark; Vice-Pres., Misses H. Penhale, E. Bietsch; *Councillor*, Sr. Mongrain, Holy Cross Hosp., Calgary; *Committee Chairmen; Institutional Nursing*, Miss A. Monteith, Galt Hosp., Lethbridge; *Private Duty*, Mrs. L. P. Garratt, 33-12th St., Medicine Hat; *Public Health*, Miss M. Fitzsimmons, 218 Administration Bldg., Edmonton; *Educational Policy*, Miss Bietsch, Gen. Hosp., Edmonton; **Registrar, Mrs. Clara Van Dusen, Ste. 5, 10129-102nd St., Edmonton.**

**Ponoka District, No. 2, A.A.R.N.**

President, Miss Geneva Battle; Vice-President, Miss Norma McDonald; Secretary-Treasurer, Miss Anne Kirkham, Provincial Mental Hospital, Ponoka; *Representative* to *The Canadian Nurse*, Mrs. Muriel Moffatt.

**Calgary District, No. 3, A.A.R.N.**

Pres., Miss B. Harrington; Vice-Pres., Miss M. Murray; Sec., Miss M. Robertson, 33 Lorraine Apts.; Treas., Miss I. Larson; *Committee Conveners: Private Duty*, Miss Robertson; *Public Health*, Miss M. Deane-Freeman; *Institutional Nursing*, Miss M. Macdonald; *Public Relations*, Miss K. Connor; *Program*, Mrs. O. Currie; *Xmas Parcels*, Miss Shaw; *Nurse Placement*, Miss M. Watt; *Ways & Means*, Mrs. E. Blair; *Reps.* to: *Press*, Miss Murray; *The Canadian Nurse*, Miss Shaw.

**Medicine Hat District, No. 4, A.A.R.N.**

Pres., Miss Marion Story, 24-1st St. S.W.; Vice-Pres., Mrs. Gordon Anderson, Miss May Shimbashi; Sec., Miss Marion MacKenzie; Treas., Miss Esther Janzon; *Social Service Convener*, Mrs. Ray Wall.

**Red Deer District, No. 6, A.A.R.N.**

Pres., Miss Olive Goodwin; Vice-Pres., Mrs. E. S. Brigham, Miss M. Exham; Sec.-Treas., Miss Alice Johnson, Municipal Hosp.; *Social Convener*, Miss Hilda Moen.

**Edmonton District, No. 7, A.A.R.N.**

Chairman, Miss M. Fitzsimmons; Vice-Chairmen, Miss C. Brown, Mrs. Hanna; Sec., Miss A. Wilson, 9219-110th Ave.; Treas., Miss M. Franko; *Program Committee*, Misses J. Morrison, E. Lea, Mrs. C. Van Dusen (registrar); *Reps.* to: *Local Council of Women*, Miss M. Fraser; *Council of Social Agencies*, Miss I. Johnson; *The Canadian Nurse*, Miss V. Chapman.

**Lethbridge District, No. 8, A.A.R.N.**

Pres., Mrs. E. Michael; Past Pres., Miss E. Hoyt; Vice-Pres., Miss A. Fallis, Sr. M. Rita; Sec., Miss G. Gorrill, Galt Hosp.; Treas., Mrs. M. Hunt, 619-11th St. S.; *Committee Conveners: Social*, Miss J. Veldhuis; *Program*, Miss D. Emery.

### BRITISH COLUMBIA

**Registered Nurses' Association of British Columbia**

Pres., Miss E. Paulson; Vice-Pres., Misses A. Creasor, J. Appleton; Hon. Sec., Miss E. Graham; Hon. Treas., Miss H. Mussallem; Past Pres., Sr. Columkille; *Committee Chairmen: Institutional Nursing*, Capt. G. McGregor; *Private Duty Nursing*, Mrs. B. Lane; *Public Health Nursing*, Miss J. Pallister; Dir., Personnel Services, Miss Evelyn E. Hood, 1101 Vancouver Block, Van.; **Exec. Sec. & Registrar, Miss Alice L. Wright, 1101 Vancouver Block, Vancouver.**

**New Westminster Chapter, R.N.A.B.C.**

Pres., Miss Grace Smith; Vice-Pres., Miss Cleta Thompson; Rec. Sec., Miss J. Gore, 415 E. Columbia St.; Corr. Sec., Miss M. Harvey, 730-14th Ave.; Treas., Miss Betty Burpee; *Rep.* to *The Canadian Nurse*, Miss P. Wright, 911 St. Andrews St.

**Vancouver Island District**

Pres., Mrs. L. Caldwell, Box 430, Port Alberni; Vice-Pres., Miss J. E. Pearson, Gen. Hosp., Nanaimo; Sec.-Treas., Mrs. D. L. Lewis, West Coast Gen. Hosp., Port Alberni; *Councillors*, Mrs. Caldwell; Miss K. Bailey, West Coast Gen. Hosp., Port Alberni; Mrs. C. Macleod, 1751 Hampshire Rd., Victoria; *Rep.* to *The Canadian Nurse*, Miss J. Ciceri, Saanich P.H. Unit, Greater Victoria.

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**East Kootenay District**

**Fernie Chapter, R.N.A.B.C.**

Pres., Mrs. M. Haile; Vice-Pres., Miss E. Jordan; Sec. and *Press Rep.*, Mrs. M. Arbuckle; Treas., and *Canadian Nurse Rep.*, Miss Myra E. Young, Box 1060, Fernie; *Committees: Visiting*, Mmes L. Hogan, Citra; *Entertainment*, Misses M. Saunders, D. Vosburgh, Mrs. M. East.

**Okanagan District**

**Kamloops-Tranquille Chapter, R.N.A.B.C.**

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**Vancouver Chapter, R.N.A.B.C.**

Pres., Miss B. McCann; Vice-Pres., Misses E. Rossiter, E. Hood; Rec. Sec., Miss B. McFaden; Corr. Sec., Miss B. Gordon, 1171 W. 32nd Ave.; Treas., Miss B. Hallam, Ste. 3, 344 W. 10th Ave.; *Committee Chairmen: Private Duty*, Miss M. Hackett; *Institutional Nursing*, Miss M. Abercrombie; *Public Health*, Miss C. Murray; *Councillors*, Misses H. Levenick, C. E. Charter.

### MANITOBA

**Manitoba Association of Registered Nurses**

Pres., Miss Christine MacArthur, 701 Medical Arts Bldg., Winnipeg; Vice-Pres., Misses D. Hibbert, E. M. Watts, A. K. Smith; *Section Chairmen: Hospital & School of Nursing*, Miss A. J. Gordon, Nurses' Res., Wpg. Gen. Hosp.; *Public Health*, Miss H. Setka, Ste. 4 Kennedy Apts., Wpg.; *General Nursing*, Mrs. M. S. Harney, Ste. 1, 696 Westminster Ave., Wpg.; **Exec. Sec. & Registrar, Miss L. E. Pettigrew, 214 Balmoral St., Winnipeg.**

## NEW BRUNSWICK

### New Brunswick Association of Registered Nurses

Pres., Miss M. E. Hunter, 282 O'Dell Ave., Fredericton; Past Pres., Miss H. M. Bartsch; Vice-Pres., Miss B. A. Beattie, Sr. Rosarie; Hon. Sec., Sr. Bujold; *Committee Chairmen: Private Nursing*, Miss M. Downing, 36 Cliff St., Saint John; *Public Health Nursing*, Miss D. Fowler, 136 Cameron St., Moncton; *Institutional Nursing*, Miss B. M. Selfridge, Gen. Hosp., Saint John; *Legislation*, Miss M. Myers, T.B. Hosp., East Saint John; *Educational Policy*, Miss K. MacLaggan, 385 Union St., Fredericton; *Health Insurance*, Miss M. E. Ingham, Victoria Public Hosp., Fredericton; *Adv. to Schools of Nursing*, Miss Myers; *Labor Relations*, Miss B. A. Beattie, Moncton Hosp.; *The Canadian Nurse*, Miss M. Dunbar, St. Stephen; *Councillors*, Misses H. J. Lynds, G. Stevens, S. Miles, Mrs. V. G. Craig; **Executive Secretary, Miss Alma F. Law, P.O. Box 846, Fredericton.**

## NOVA SCOTIA

### Registered Nurses' Association of Nova Scotia

Pres., Miss K. Harvey, Roseway Hosp., Shelburne; Past Pres., Miss M. K. Miller; Vice-Pres., Miss J. Forbes, Mrs. D. McKeown, Sr. C. Gerard; Rec. Sec., Miss D. Gill; *Committee Chairmen: Public Health*, Miss P. Lyttle, N.S. Dept. of Public Health, Halifax; *Institutional Nursing*, Sr. M. Estelle, Halifax Infirmary; *Private Nursing*, Miss J. Watkins, 217 Robie St., Hfx; *Legislative*, Miss E. MacLennan; *Educational Policy*, Miss L. Grady; *Public Relations*, Mrs. H. Stacey; *Nominating*, Miss R. Myers; *Discipline*, Miss S. Archard; *Adv. to Registrar*, Miss J. Church; **Sec.-Registrar, Miss Nancy H. Watson, 301 Barrington St., Halifax.**

## ONTARIO

### Registered Nurses' Association of Ontario

Pres., Miss G. J. Sharpe, Western Hosp., Toronto 2B; Vice-Pres., Misses B. M. Beyer, M. P. Stiver; *Interest Committee Chairmen: Institutional Nursing*, Miss J. E. Young; *Private Nursing*, Mrs. E. Brackenridge; *Public Health Nursing*, Miss J. C. Leask; *District Chairmen: Dist. 1*, Miss E. R. Horton, 16–3rd Ave., St. Thomas; *2 & 3*, Mrs. J. C. Sanders, 32 Wellington St. W., Woodstock; *4*, Miss I. Mayall, Gen. Hosp., Hamilton; *5*, Miss M. I. Tresidder, 170½ St. Clair Ave. E., Toronto 5; *6*, Miss H. McGeary, V.O.N., Belleville; *7*, Miss M. A. Fairfield, Dept. of Health, Kingston; *8*, Miss L. M. Langford, 22 Melgund Ave., Apt. 2, Ottawa; *9*, Sr. St. Camillus, St. Joseph's Hosp., North Bay; *10*, Mrs. D. R. Easton, 35 Maudslay Crt., Port Arthur; **Sec.-Treas., Miss Florence H. Walker, 515 Jarvis St., Toronto 5.**

#### District 1

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#### District 4

Chairman, Miss I. Mayall; Vice-Chairmen, Misses E. Ewart, D. Sharpe; Sec.-Treas., Miss Clara Graham, 102 Dalewood Ave. S., Hamilton; Asst. Sec., Miss G. Coulthart; *Committee Conveners: Institutional*, Miss G. Blyth; *Private Duty*, Miss H. Cybulski; *Public Health*, Miss D. Marshall; *Councillors*, Misses M. Blackwood, E. Freeman, A. Oram, B. Lousley, B. Key, M. Campbell.

#### District 5

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#### District 6

Chairman, Miss H. McGeary; Vice-Chairmen, Miss R. Cunningham, Mrs. M. Pringle; Sec.-Treas., Mrs. J. Patterson, Civic Hosp., Peterborough; *Committee Conveners: Institutional Nursing*, Sr. Benedicta; *Private Nursing*, Mrs. W. Donaldson; *Public Health*, Mrs. E. Nattress; *Industrial Nursing*, Miss M. Greer; *Membership*, Miss G. Clark; *Finance*, Mrs. H. Roy; *Nominating*, Miss C. Droppo; *Rep. to The Can. Nurse*, Miss M. Sheppard.

#### District 7

Chairman, Miss M. A. Fairfield; Vice-Chairmen, Sr. Mantle, Miss C. Mullins; Sec.-Treas., Miss M. Laturney, Dept. of Health, Kingston; *Committees: Private Nursing*, Miss B. Blackman; *Public Health Nursing*, Miss L. Wall; *Institutional Nursing*, Miss L. D. Acton; *Membership*, Miss Ella G. Smith; *Bursaries*, Miss H. Corbett; *Finance*, Miss G. Conley; *Nominations*, Miss H. Hogan; *Program*, Miss L. D. Acton; *Education*, Miss Fairfield; *The Canadian Nurse*, Miss M. I. Somerville; *Councillors*, Misses B. Griffin, A. Church, O. Wilson, Mrs. L. Park, Sr. M. Patrice.

#### District 8

Chairman, Miss L. Langford; Past Chairman, Miss A. Landon; Vice-Chairmen, Misses M. Nephew, V. Adair; Sec., Miss M. Phillips, 66-5th Ave., Ottawa; Treas., Miss I. Dickie; *Councillors*, Sr. M. Evangeline, Misses G. Boland, D. Browne, M. Woodside, A. Saunders, M. Lamb.

#### District 9

Chairman, Miss Lois Smith; Vice-Chairmen, Miss E. Houston, Rev. Sr. Camillus; Sec.-Treas., Miss M. Rice, Box 377, Haileybury; *Section Conveners: Hospital & School of Nursing*, Miss E. B. Walsh; *General Nursing*, Miss D. White; *Public Health*, Mrs. M. Stewart; *Committee Conveners: Membership*, Miss I. Black; *Program*, Miss S. Burke; *Nominations*, Miss A. Huhta; *Finance*, Mrs. H. G. McLean; *Rep. to The Canadian Nurse*, Rev. Sr. Sheila.

#### District 10

Chairman, Mrs. D. R. Easton; Vice-Chairman, Sr. Patricia; Sec.-Treas., Miss H. Keith, 176 Peter St., Port Arthur; *Committees: Finance*, Miss D. Colquhoun; *Membership*, Sr. Monica, Miss M. Flanagan; *Program*, Miss H. Scriminger, Mrs. G. Ward; *Nominating*, Mrs. R. Cunningham, Misses D. Elliott, Scriminger; *Sections: Public Health*, Miss Sisson; *Institutional Nursing*, Miss M. Stitt; *Councillors*, Sr. Felicitas, Misses A. B. Hunter, B. Stock, K. Feisel; *Reps. to: Press*, Miss E. Davidson; *The Canadian Nurse*, Misses A. Malmborg, F. Howard.

## PRINCE EDWARD ISLAND

**The Association of Nurses of Prince Edward Island**

Pres., Sr. M. Stanislaus, Charlottetown Hosp.; Vice-Pres., Miss V. Darrach, 62 Prince St., Charlottetown; Miss H. Arsenault, Provincial Sanatorium, Charlottetown; Hon. Sec., Mrs. M. Maddigan, 125 Pownal St., Charlottetown; Hon. Treas., Miss K. MacLennan, Prov. San., Charlottetown; *Section Chairmen: Private Duty*, Mrs. M. Storey, York Lane, Charlottetown; *Institutional Nursing*, Sr. John the Baptist, Charlottetown Hosp.; *Public Health*, Miss R. Ross, 57 Orlebar St., Charlottetown; **Sec.-Registrar, Miss Muriel Archibald, 188 Prince St., Charlottetown.**

## QUEBEC

**The Association of Nurses of the Province of Quebec**

**The Association of Nurses of the Province of Quebec, created by Licensing Act, April 17, 1946, replacing The Registered Nurses Association of the Province of Quebec, Incorporated February 14, 1920.**

Pres., Mlle A. Martineau, 671 ave Ogilvy, Montréal 15; Vice-Pres., (*Eng.*), Sr. M. Felicitas, Miss H. Lamont; (*Fr.*), Sr. St. Ferdinand, Mlle J. Gagnon; Hon. Sec., Mlle G. Charbonneau; Hon. Treas., Miss I. Black; *Councillors*, Mlles C. Julien, C. Demers, L. Couet, F. St. Pierre, Miss V. Graham. The above constitute the *Executive Council* and are *Members of the Committee of Management*, together with: Mlles B. Laliberté, M. Bissonnet, M. Lacombe, A. Mailloux, M. A. Trudel, F. Verret, P. Crevier, Misses M. Wheeler, A. Peverley, D. Goodill, Mère Marie-Paule, Sr. St. Damase. *Advisory Com.*, Misses G. M. Hall, M. Mathewson, E. Flanagan, C. V. Barrett, Mlles R. Aubin, G. Lamarre, Mme M. Boisvert, Mrs. J. Green, Sr. Valérie de la Sagesse. *Com. Chairmen: Institutional Nursing* (*Eng.*), Miss G. Purcell, Royal Victoria Hosp., Mtl 2; (*Fr.*), Sr. Denise Lefebvre, Institut Marguerite d'Youville, Mtl 25; *Public Health* (*Eng.*), Miss M. Gage, 894 Osborne Ave., Verdun, Mtl 19; (*Fr.*), Mlle E. Merleau, 5302 ave Victoria, app. 2, Mtl 26; *Private Nursing* (*Eng.*), Miss H. Cameron, 3015 Sherbrooke St. W., Mtl 25; (*Fr.*), Mlle A. Gauvreau, 1482 rue Closse, app. 14, Mtl 25; *Chairmen, Board of Examiners*: (*Eng.*), Miss A. Haggart, Royal Victoria Hosp., Mtl 2; (*Fr.*), Mlle J. Trudel, Hôp. Ste. Justine, Mtl 10. **Sec.-Registrar, Miss Margaret M. Street. Visitor to French Schools of Nursing, Mlle Suzanne Giroux. *Association Headquarters*, Suite 504-6, 1538 Sherbrooke St. W., Montreal 25.**

### District 1

Chairman, Mlle C. Julien, St-Charles Garnier, Cté Rimouski; Sec., Rév. Sr. Laurette de la Ste-Face, Sanatorium St-Georges, Mont-Joli.

### District 2

Chairman, Mlle C. Demers, 49 rue Poirier, Charny, Cté Lévis; Sec., Mlle C. Aubert, 25 rue Commerciale, Lévis.

### District 3

*English* Chapter: Chairman, Miss V. Graham, Sherbrooke Hospital; Sec., Miss C. Bernard, Sherbrooke Hospital. *French* Chapter: Chairman, Mlle Ruth Aubin, East Angus, Cté Compton; Sec., Rév. Sr. St-André, Hôp. Général St-Vincent de Paul, Sherbrooke.

### District 4

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